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ABSTRACT

This is a transcript of a hearing held to examine the extent and causes of hunger in the United States. Witnesses presenting testimony included a Boston pediatrician, two representatives from the Physician Task Force on Hunger in America, the Chairman of the House Select Committee on Hunger, and a professor at the Johns Hopkins School of Hygiene and Public Health. The testimony focused on the inadequacy of current programs for addressing the magnitude of hunger in the country. Anecdotal accounts, statistical data, and other research findings were offered to support calls for additional funding in public assistance programs that provide nutritional support. Finally, a Heritage Foundation representative argued that hunger is not as prevalent as the witnesses had claimed. (GC)

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POVERTY AND HUNGER IN AMERICA

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HEARING

BEFORE THE

SUBCOMMITTEE ON PUBLIC ASSISTANCE AND UNEMPLOYMENT COMPENSATION

OF THE

COMMITTEE ON WAYS AND MEANS HOUSE OF REPRESENTATIVES

NINETY-NINTH CONGRESS

FIRST SESSION

APRIL 30, 1985

Serial 99-4

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POVERTY AND HUNGER IN AMERICA

TUESDAY, APRIL 30, 1985

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON PUBLIC ASSISTANCE AND
UNEMPLOYMENT COMPENSATION,
Washington, DC.

The subcommittee met at 2 p.m., in room B-318, Rayburn House Office Building, Hon. Harold Ford (chairman of the subcommittee) presiding.

[The press release announcing the hearing follows:]

[For immediate release, Monday, April 22, 1985]

THE HONORABLE HAROLD FORD (D., TENN.), CHAIRMAN, SUBCOMMITTEE ON PUBLIC ASSISTANCE AND UNEMPLOYMENT COMPENSATION, COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES, ANNOUNCES A HEARING AND FIELD VISIT TO INVESTIGATE GROWING POVERTY AND HUNGER IN AMERICA

The Honorable Harold Ford (D., Tenn.), Chairman, Subcommittee on Public Assistance and Unemployment Compensation of the Committee on Ways and Means, U.S. House of Representatives, announced today that the Subcommittee will hold a hearing and local field visit in Washington, D.C., on Tuesday, April 30, 1985, to investigate growing poverty and hunger in America.

In announcing the hearing, Chairman Ford said, "For the past two years, we have held hearings and received many written reports detailing the miserable circumstances facing the poor of this country. It is time for the Subcommittee to learn first hand about the problems and experiences faced by our less fortunate citizens. The fact that we can find stark examples of poverty and hunger within sight of the Capital is a sad commentary on our times."

On Tuesday, April 30, 1985, the Subcommittee and other invited guests will visit the Comprehensive Health Care Clinic operated by Children's Hospital and the Associated Catholic Charities/Sacred Heart Social Services Center in Washington, D.C. Later in the day, at 2:00 p.m., in Room B-318 Rayburn House Office Building, the Subcommittee will hold a hearing on the growth of poverty and hunger in America.

The witnesses at the hearing will be Dr. Larry Brown, Chairman of the Physician Task Force on Hunger in America and several other doctors who participated in the Task Force research. Only invited witnesses will testify; public witnesses will be invited to testify at a subsequent hearing on poverty to be announced at a later date.

WRITTEN STATEMENTS IN LIEU OF PERSONAL APPEARANCES

Persons submitting a written statement for the record of the hearing should submit at least six (6) copies of their statements by the close of business, Tuesday, May 7, 1985, to Joseph K. Dowley, Chief Counsel, Committee on Ways and Means, U.S. House of Representatives, Washington, D.C. 20515. If those filing written statements for the record of the printed hearing wish to have their statements distributed to the press and the interested public, they may provide 75 additional copies for this purpose to the full Committee office before the hearing begins.

Chairman FORD. The Subcommittee on Public Assistance and Unemployment Compensation of the Committee on Ways and Means will come to order.

This is the second part of a day long field trip and public hearing held by the Public Assistance Subcommittee. The subcommittee joined with the Physician Task Force on Hunger in America, headed up by Dr. Larry Brown of Harvard University, and this morning at 8:30 we were able to make several site visits. We were able to split up members of the Physician Task Force, as well as members of this Subcommittee on Public Assistance, to make two home visits apiece, which gave us a total of four. And we are very pleased that we had an opportunity, Dr. Brown and other members of your distinguished panel, that we had an opportunity to go out and see for ourselves some of the problems which you reflected in the report that you have submitted to the American people. I must say that all is not well in America.

Thirty-five million U.S. citizens live in poverty. Nearly half of all black children are poor. The poverty rate for children in female-headed households is even higher. According to a respected team of doctors, 20 million Americans go hungry at least 2 days a month.

Yet President Reagan would have us believe that the safety net is catching all of the truly needy and the cuts made to social programs were only those necessary to trim the fat. You trimmed the fat, Mr. President, but you also took a good part of the meat. The children of this Nation are suffering and we are spending today learning just how much.

This morning the subcommittee traveled just a few miles from the Capitol to visit a local health center operated by Children's Hospital. We learned about the many poor families served by the clinic who cannot qualify for Federal Medicaid benefits. We learned that this busy health clinic has funds to aid only a fraction of the mothers and children who might be eligible for the WIC Program. We also talked with several families in their homes about how hard it is to cope on their meager incomes. We visited a Catholic Charities Social Service Center, which distributes 50 bags of groceries per week, provides emergency cash assistance to countless others, and does so with almost no Federal funds. The bottom line may surprise the President but it is no real surprise to me. Poverty has increased and the budget cuts of the past few years have had a devastating impact on the poor children of this Nation.

It is now time to once again turn to the experts. I am particularly pleased that Dr. Larry Brown, chairman of the Physician Task Force on Hunger in America, and several of his distinguished colleagues have been able to join us today.

Doctors, I have read your report and ask you to tell us three things:

Is there hunger and poverty in America?

What is it doing to our Nation's children?

What can the Congress do to help?

Before we turn to you, I first would like to welcome a nonmember of the Public Assistance Subcommittee, who is also the author of the legislation that has been introduced in the hopper, and I understand that this distinguished group has already embraced the legislation that has been introduced in the Congress by the chairman of the Hunger Committee here in the Congress, Mr. Leland of Texas. We will recognize him in a few minutes.

But I would like to recognize the ranking minority member at this time for any opening remarks that he might have.

Mr. CAMPBELL. Thank you very much, Mr. Chairman.

I want to commend you for going on the field visits this morning. I am sorry that I was unable to go with you. I had a long-standing conference on a health problem, and they told me I could not reschedule it until May 25. Therefore, I was not able to go with you.

I would like to tell you that over the past 15 months, the Republican members of the subcommittee have been working in soup kitchens and visiting the homeless and doing so without benefit of press or notification. We have worked as volunteers. We worked in Catholic charities, we worked in Baltimore, we have worked in the Washington, DC, area, and the purpose of all this was to determine exactly what some of the problems were first hand without a structure of people or professionals to tell us what they were, but essentially to look at and determine on our own what the problems were.

An interesting thing is, some members who did this are no longer on this committee. The ranking committee member, Barber Conable, was out and working with us, for example.

We took some private photographs for the purpose of trying to examine conditions. There are problems, and we have worked on corrective legislation, and this legislation will be introduced in the next couple of weeks and will be shared for others to look at and to determine whether it solves some of the problems, or whether it can be put together with other ideas to deal with the problems. There are, as I have said, difficulties. There are many things that we found.

Yes, there are families with children in need of health care, who need food, and we should deal with that. We have had problems in this country with probably a third of the people on the street who have been deinstitutionalized or who were under some medical care, and are no longer taking medication. Because in the efforts of society here to mainstream people, they have been put out without the proper places to go. And they struggle on the streets today, whereas if there were some control, they would maintain their medication, they would maintain some control over that which is destabilizing them. And we need to address that. We need to address it as a Congress, not from a partisan standpoint, or from a standpoint of the Congress versus the administration, but from a people's standpoint.

The reason that we wanted to start gathering this information over a period of time was so that when we had a sufficient amount of information that we would be able to engage in and participate in this debate on hunger and all these related problems, and we would be able to work constructively, but we would be able to work constructively with firsthand knowledge and not simply from being told.

And so I welcome you here today and your efforts and what you are doing. And, Mr. Chairman, I am again apologetic for not getting to participate with you. And I do want to congratulate you again for taking these trips. And we would be glad to share with, obviously, you or other members any of the findings that we have in the report, and look forward to working with you.

Chairman FORD. Let me assure you, Mr. Campbell, that we welcome any and all of that information before this subcommittee, and I certainly would like to make you privy to that information. But I think that, you know, the chairman of this committee joins with three or four members of this subcommittee this morning, and when I think in terms of 1981, whether it is the WIC Program, Aid to Families With Dependent Children, the Medicaid cuts that took place, the cuts in title 5, title 20, unemployment compensation being dismantled through the Extended Benefits Program, FSC, unemployment still at 3 or 4 percent, the same rate as when Reagan took office. It goes beyond the soup line. We are talking about babies, we are talking about children, we are talking about infant mortality, we are talking about poverty at its worst. We are talking about 35 million people who are living below poverty. We are talking about people who are going hungry, no food in their refrigerators.

In the latter part, the latter days of any given month, children are going hungry, mothers are going hungry, poverty is there. We must address this particular issue with or without the support of the White House. We must say to the poor of this Nation that we see that there are real problems.

And I am proud to know that you, Mr. Campbell, and others on the minority side know that these problems are there through the soup lines. But we must go beyond that. We must try to evaluate some of these severe cuts that took place in the last 4 years and try to redefine where we should go in the future and say to those who have slipped below the poverty level and those who are going hungry 2 to 4 days out of the month, we will not let this happen in this Nation.

Mr. CAMPBELL. Mr. Chairman, I certainly agree with most of the thrust of what you just said. We also must go beyond it and determine why we have four- and five-generation welfare in this country and what we can do to break that cycle. We must go beyond to determine what we can do to help people get off of assistance, not maintain them on long-term assistance, and I think that is what you are striving for. And I hope that is what everyone else is striving for, and that is to literally and completely help people become self-sustaining as best we possibly can. That should be our goal.

It should not be a goal of maintenance. It should be a goal of gradually helping people to find a flight of stairs which they can climb to the point that they themselves are independent and can cope. And there are many problems. There are mothers who receive food stamps, whose food stamps have been stolen in the streets before they can spend them, and have to go to charity for food. And they run out before the end of the month. There are people who use food stamps as a currency in the street for drugs or alcohol. And there are people who go hungry because of it.

These are problems that have to be addressed and I think working together we have to address what cuts have to be restored. Some of them I am sure you and I would agree on. But I do not think that is enough. I think we would need to go beyond that. And I hope that as we delve into this subject that we will look at it in complete breadth and depth.

And I again look forward to hearing from and participating with the panel.

Chairman FORD. Mr. Campbell, I will end this scenario. This is typical. It hurts to know that you would inflict even greater wounds upon the poor and the indigent of this Nation by talking about food stamps being transferred for whatever means in the streets. That 1 percent might happen, but I say to your party look at the defense budget and look at billions of dollars that General Dynamics, General Electric, and you would intimidate the poor like this.

Mr. CAMPBELL. Mr. Chairman, I resent your taking that out of context.

Chairman FORD. Then you have to resent it, Mr. Campbell. You should have been with us this morning.

Mr. CAMPBELL. You should have been there without benefit of press.

Chairman FORD. The committee will be in order.

I will recognize Mr. Matsui.

Mr. MATSUI. Thank you, Mr. Chairman.

Mr. Chairman, I just want to take a few minutes, if I may. I want to commend you for the field hearing you had today, and I do wish other members, not just the Republican members, but Democratic members as well, particularly Members of the Senate, have the chance to see what we saw today. I have to commend you for having the field hearing and also this hearing today. And as you indicated, we are going to have more, and I look forward to participating with you.

I think the experience I had today goes beyond pure legislation, and I just appreciate having had that experience very much. It will make me a better legislator, I will tell you.

We went to the Comprehensive Health Care Clinic, as run by the Children's Hospital, and we discovered there that out of the 26,000 children that had been serviced there, only 6,000 were covered or had been covered by Medicaid through AFDC and others are being covered through private and charitable contributions and by the District government. Thank goodness, the District government has the funds in order to take care of these young children because if they did not have those funds, certainly we could see many more problems than we do today. And we had an opportunity to go on Sherman Avenue and meet with a family. It looks like a very typical middle-class family when you drive down the street of Sherman Avenue where we were. But when we walked into the house, we found that there were seven people living in it. It was a tidy house in the sense that it was clean, and there were not things lying around. At the same time, we had a 92-year-old mother there, a 34-year-old daughter, and she had a 17-year-old daughter that had a 1-year old child. And there were three other young children there as well, seven altogether in the family, four generations in that one household.

We discovered that the 1-year old child weighed only 13 pounds, 13 plus pounds, when she should have been up to 20 pounds. And it was obvious, Mr. Pease and I were talking with the mother and trying to get a reaction from the child, and she was not responding like my son did when he was 1-year-old. I think it was pretty obvi-

ous that that child was suffering, from what I do not know, but suffering.

We had the opportunity to go down in the basement and go through their kitchen. And I had to tell you I was absolutely astonished because I want to believe the President in fact took care of those people, and that there is a safety net. The door to the refrigerator was opened for us—and bear in mind that this is seven people in this family, and there was no milk, there was no juice, there was a bare refrigerator. It was astonishing to me. It was almost as if you could walk into a department store and open that refrigerator door and find absolutely nothing there. The shelf side of the door was bare completely. There were a few things, but there was nothing to eat.

And we asked if we could see their cupboards. And we opened up the cupboards, and I guess there was box—I guess it was Chef Boyardee that had just a very little in it, and that was it. Mr. Pease asked the 34-year old mother how she was going to feed the other six in the family. She just said that its the end of the month, and after the first of the month we will be able to do it. We found that their total monthly payments for AFDC was under $600, and that would include rent and whatever expenses that family had. And it was just absolutely astonishing. I wish the other members had the opportunity to visit a home like that because it was very moving. And these people there were not transients. They were people who were trying hard. They kept the house as clean as they could. They were dressed as perfectly as they could. And they were people who wanted to be in the mainstream but, obviously, they were not. They were not allowed to.

I do not want to blame it on Government or what, but they were not allowed to. And maybe that is anecdotal because some people say it is anecdotal. I wondered if Sacramento has the same type of situation. And I asked my staff to call up some people in Sacramento, and they indicated to me through their research that over 6,000 families in Sacramento County alone will be homeless this next year. We had a Front Street shelter which provided 116,000 sheltered nights for people, and they are not transients either because of these 4,210 individuals who use the shelter, of that 4,210, 65 percent have lived in Sacramento for 5 years. So these were not transients; these were people who lived in Sacramento County, 3,000 plus. And we are not talking about individual adults.

The Sacramento Housing and Redevelopment Agency placed 264 families in housing last year; 264 obtained housing. That does not include those that did not get housing. And of these families, there were 468 children below the age of 5 who had been living in the streets prior to being placed by our Housing and Redevelopment Agency. I do not know how many now are without shelter, how many have not been placed. But there must be many out there if we have over 6,000 families homeless this coming year.

Our community is a reasonably prosperous community, it is not like Washington, DC. Mr. Chairman, I would have to say that, you know, we have seen an increase in the poverty rate of the 11.9 percent or so in 1980, it is now up to 15.2 percent. And it has basically hit single parents with children, and that is whom we saw today. I just think that we, as the Congress, and the President, have a re-

sponsibility that goes beyond your legislation. And we had better begin to address that problem because we have an underclass in America today, and I saw it for the first time. And I do not like what I saw.

I just think that we ought to work together to solve that problem.

Thank you, Mr. Chairman.

Chairman FORD. Mr. Matsui, tell us about that visit, one of the visits to the homesite. We had the occasion to go to the Sacred Heart Catholic Charities today, and we found about seven or eight young men in the front of the office. And as we talked with them, all were looking for some kind of work through the D.C. Employment Services. All had their cards on which they reported in every day. None receive any type of public assistance, welfare, food stamps. All were seeking that job. Some mentioned to us that they had gone without food today; one or two mentioned the fact that they had no food yesterday. And they were there at the charities today to try to identify some source of food or some soup line later today.

Did you find it true with the visits that you made today that the people wanted to work and not remain on the public welfare rolls or be dependent upon the Government for some sort of payments; that they wanted employment, seeking employment?

Mr. MATSUI. Mr. Chairman, I could not say that with respect to the family that we visited today. It appears frankly their decision is somewhat hopeless. They have young children in the household. They have a 92-year-old mother to take care of. I do not know how that 34-year-old woman would be able to find any employment. She has too many other responsibilities. She is the single individual who is going to run that household with the 17-year-old and the 92-year-old. There is just no way she could even consider employment in her situation. I think she is trapped and that is a tragedy.

And, you know, the real tragedy as I see it, she is getting benefits and she is still trapped, you know. And so what little we have afforded her really has not increased the quality of her life. And I was really shocked. I have to say I was really shocked at what I saw today.

Chairman FORD. I think there was another scenario that we were able to witness today with AFDC, the food stamps, in a case where the mother with three children was pushed out of the work force through no fault of her own some 18 months ago. Her husband had a job. She was working, gainfully employed. I think her husband was gainfully employed, with three children, and through the WIC program, AFDC and food stamps, it is a clear case that a person is making it with the system, three kids, through the WIC Program, looked to have been very, very healthy although it was critical times for the last 2 weeks of the month.

We looked in her refrigerator, and she indicated that through maybe eggs, beans, through the latter few days of the month, it was very, very tough for her to put things together although, because of the WIC Program, she was able to provide food for the children. And I think the Director of the Health and Human Services for the District of Columbia, he indicated to us that the service reached out to about one-third of the total number of children that

would really qualify under the WIC Program, for whatever reason they are not qualified under this.

Mr. MATSUI. Mr. Chairman, I would like to add one comment. When we went to the Health Care Clinic, we had seen a woman who was administering the way the payments were made to the recipient of the benefits. And there is no way that cheating can be done. A voucher had been prepared and was sent out to the Safeway Stores in the neighborhood with the specific grocery items listed that could be purchased with that voucher. No more and no less. This lady was given four vouchers which would take care of her for 4 straight weeks, one per week. And it was basic food staples. It did not have beer, wine or anything like that. It had bread, juice, milk, and those nutritional requirements for that child. And so there is no cheating.

Mr. Campbell may have some of those problems wherever he may be looking, but certainly there cannot be a problem under the circumstances that you and I saw because it was specific items that you could purchase with that voucher unless Safeway itself is going to cheat.

Chairman FORD. Mrs. Kennelly.

Mrs. KENNELLY. Thank you, Mr. Chairman, and Dr. Brown for taking us out today and showing us some of the things you did. And I come from an urban center, live in a city that has similar problems too. And this was not all new to me by any matter of means. But some things came through very clearly.

We were at the hospital, and they told us that they really were able to take care of one-third of the number that was targeted; two-thirds they were not addressing.

Then we went to the two homes that the chairman and I went to. And we saw beautiful children. Things were working.

I would like to ask you a couple of broad questions.

Chairman FORD. Mrs. Kennelly, these are opening statements.

Mrs. KENNELLY. I have a lot of questions that I will not ask now.

Dr. Brown, we saw a great deal today, only in one day, and I am glad you were here with us. And I compliment you on your report because you are looking at the broad picture and you are seeing things that work and things that do not work. And I look forward to working with you because I think what the chairman has been so good about in this whole venture is that what we are trying to do is reach out and see what is working and is not working. And if we have the tools and see how we can do things, I am confident we can make changes for the good.

I know you have traveled a bit of my State. You have also been throughout this country. I am interested in hearing what you have to say about what is going on in this country, what we can do more and do better.

Thank you.

Chairman FORD. We have Mr. Leland joining us today, and at this time the Chair will recognize Mr. Leland.

STATEMENT OF HON. MICKEY LELAND, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS, AND CHAIRMAN, SELECT COMMITTEE ON HUNGER

Mr. LELAND. Thank you, Mr Chairman.

I am happy once again to be in the company of Dr. Brown and his colleagues. They have done such commendable work in informing the American people about the far-reaching hunger problems being experienced in this Nation.

By the way, Mr. Chairman, I am pleased to hear about your tour this morning. I feel that the media having accompanied you will help bring the American people closer to the reality of hunger and poverty in our communities throughout this country. I hate to sound so partisan right now, but I think we have to raise the partisan issue when the minority party of this Congress is so intent upon cutting the so-called welfare programs. These are social programs that have been beneficial to so many people over the last few years. Many of the people participating in these programs have been able to reach out beyond the mire of hunger and poverty. It has been only with the help provided through these programs that they have survived and have broken the poverty cycle. We are now witnessing a reversal of these trends because of the administration's policy toward poor people.

It seems there is a looming, ever-present policy which is reducing the opportunities poor people have to break the cycle of poverty. I am sorry that Mr. Campbell is not present to hear my statement. I hope that he reads the record and benefit from my words.

The policies of the Reagan administration have hampered, not helped, the poor from breaking out of the so-called four generation poverty cycle. The administration has not offered any other alternative programs to replace those which they have looked upon with such great disdain. The Select Committee on Hunger, which I chair, has conducted field investigations, too. We have talked to people existing under the same circumstances that you saw today, Mr. Chairman. We have seen devastation present all around us. In 1985, we went to Greenwood, MS, where we saw poverty at its worst. We saw young children crying out for food. We learned a long time ago that if you feed a hungry child, that hungry child can learn and develop a healthy mind. He can escape his destitution by going to school and matriculating, not only through the elementary school grades, but perhaps also going on to college. He is then prepared to become a productive citizen. We saw evidence that some children—those who are not properly fed—will be stymied not only in their physical growth, but also in their mental growth. This will commit them to the worst kind of destiny. They may be totally dependent on the State, if you will, and upon programs that are paid for by the taxpayers.

Also, we have discovered in our findings that it is cost-effective for us to spend moneys on the programs that you have alluded to—the Food Stamp Program and WIC.

Mr. Chairman, I grew up in a community much like the one you saw this morning. The living conditions Mrs. Kennelly has described are not new to me. Every day that I go back to my district and I walk through the so-called ghetto, an area that many of us

call home, I am very frustrated because I do not know exactly what we can do as individual Members of Congress or even as a unified Congress to make changes.

Perhaps I spoke incorrectly. I do know what we can do; however, I am not sure that the political will is here to make the necessary changes. When an administration will attack WIC, the program that has been deemed the most effective and efficient federally sponsored program ever to be instituted, then something is very, very wrong.

Mr. Chairman, I would suggest to you that you must move forward. I am so happy to be here as chairman of the Select Committee on Hunger among some of my colleagues who are very interested in the hearing topic today. There is something to be said about a Nation that stores millions of metric tons of foodstuffs in silos. And we still are not dispensing those foods. We pay our farmers millions of dollars in subsidies not to grow crops on their land.

In fact, we could release the stored surpluses and provide the kinds of food not only necessary to feed the people in this country but people all over the world. This country has the ability to feed every man, woman, and child on the face of the Earth. The problem we encounter is lack of political will to do it. We must move forward together to make sure that that political will is not suppressed. It is a good step in my estimation, for us to present this case to the public through our media. If the people of this country know what is really going on, I know they are going to demand their Members of Congress and their President do all that is necessary to stop the rampant hunger being realized in this country.

Thank you, Mr. Chairman.

Chairman FORD. Thank you, Mr. Leland.

At this time the subcommittee will recognize Dr. Larry Brown, who is the chairman of the Physician Task Force on Hunger in America, of Harvard University School of Public Health. Along with him is Dr. Gordon Harper of the Judge Baker Guidance Center of Boston, MA; Dr. William Beardless, clinical director of the Department of Psychiatry, Children's Hospital Medical Center of Boston, MA; and Dr. Sam Shapiro, professor of health policy and management of the Johns Hopkins University of Baltimore, MD.

We are delighted to have you with us.

Once again, Dr. Brown, Dr. Harper, thank you for joining with us this morning. We certainly enjoyed being with you, and we look forward to hearing from you.

We recognize you, Dr. Brown.

STATEMENT OF J. LARRY BROWN, PH.D., MEMBER OF THE FACULTY, HARVARD SCHOOL OF PUBLIC HEALTH, AND CHAIRMAN, PHYSICIAN TASK FORCE ON HUNGER IN AMERICA

Mr. BROWN. Two days ago nationally syndicated cartoonist Garry Trudeau depicted Michael, in the "Doonesbury" strip, out looking for America's 20 million hungry citizens at the insistence of his minister.

Finally, in exasperation, Michael exclaimed, "But they're invisible." With a knowledgeable look on his face his minister said in response, "See what I'm up against."

I appreciate the efforts of this subcommittee to look after the well-being of poor families and individuals in America. At no time in recent history has your challenge been so difficult.

Hunger and poverty, pain and suffering in this rich land generally are hidden from view, and often are beyond the concerns of public officials. There is definitely another side to America—a side which I and other members of the Physician Task Force on Hunger in America found as we traveled across this land.

On the other side of America live millions of citizens in degradation and hopelessness. The plight limits our moral authority as a nation and undermines the benefits of a democratic society.

Benjamin Thompson lives on the other side of America. This 53-year-old Army veteran lost his job when the Caterpillar plant closed in Peoria. His unemployment benefits ran out and his family now eats in a soup kitchen. With no electricity, his children do their studies by candlelight.

Of the Nation's 8.4 million jobless, 70 percent receive no unemployment benefits.

Randall Davis lives on the other side of America. Once a middle-class head of household, this Houston father of two was forced to desert his wife and children to make them eligible for AFDC so they could eat.

Twenty-seven States refuse to provide AFDC unless the father first leaves the home.

Timmy and Regina Johnson are 4-year-old twins who live on the other side of America. Their mother's part time job, along with AFDC, fails to bring the family above the poverty line.

Over 35 million Americans live below poverty in the world's wealthiest Nation.

I am invited to appear before you today because of my knowledge about hunger in America. But hunger is merely a symptom of poverty. It reflects the growing income disparity among people in our Nation.

Nearly 20 years ago another group of physicians went into the backwaters of America. What they found was not pleasant:

> If you will go look, you will find America a shocking place. No other Western country permits such a large proportion of its people to endure the lives we press on the poor. To make four-fifths of a nation more affluent than any other people in history, we have degraded one-fifth mercilessly.

For a time our Nation made great strides in improving this situation. The rate of poverty declined; the problem of hunger virtually vanished. But today we see clear deterioration. Of the 35 million Americans in poverty, an estimated 20 million go hungry every month.

Today I want to share what we learned about impoverishment from talking with the hungry and with those who try to feed them.

Impoverished Americans desperately want jobs. "If I could get another job,: one unemployed mother told us, "I could feed my own family again. That's all I want." When our physicians went into homes to find empty refrigerators and children without milk, we asked what they most wanted. Almost without exception the answer was a job.

Hopefully, all will agree that these Americans should have jobs. But the central issue is what our Nation is to do when the economy

fails to employ our families. What do we do to protect them during their economic insecurity?

Compared to what our impoverished families need, the American safety net is really a band-aid. It is a hodge-podge of programs which is inadequate to raise families, and it penalizes those who try hard to get ahead. Let me provide several examples:

1. GENERAL INADEQUACY OF THE SAFETY NET IN AMERICA

The official poverty level represents the level below which our Federal Government determines it is impossible to meet minimal and decent living standards. In other words, the U.S. Government recognizes that a family in poverty has not the minimal resources to meet the basic needs of its members.

It is in this light that we must face the fact that we force 35 million of our citizens to live below substandard levels.

Let us look briefly at the two basic programs for which an impoverished family may be eligible; the AFDC and food stamps. Today, in no State in the Nation does the average family receiving benefits from these programs come even close to the poverty level.

In Alaska, the State with the highest benefits, a family of four receives only 89 percent of poverty when helped by these two programs. In Kansas, at the midpoint, that family gets 69 percent of poverty. And in Alabama, the State with the lowest assistance levels, parents are supposed to raise children on 46 percent of the poverty level.

In short, as a matter of public policy, America's treatment of its poorest families is indecent.

Under such circumstances, it is virtually impossible for most families to pull themselves out of difficult economic circumstances. By forcing families to live indecently, we foster disorganization and disintegration. Rather than providing a little extra to assist our people to get on their feet, we provide less. Our safety net programs are penny wise and pound foolish. In hurting our families, we hurt America.

2. SAFETY NET PROGRAMS ARE MORE PUNITIVE THAN HELPFUL

When the Government helps a middle-class youth attend college, or when it gives Government aid to corporations, it is given in a positive manner. When aid is given to the poor, it is usually given in a punitive and mean-spirited manner.

As we traveled across the country, we found the "new poor" astounded at how they are treated now that they are penniless. As former taxpayers, they had assumed that Government programs helped the downtrodden. Now that they are recipients, they enter a world of degradation and mean-spiritedness.

"To get help," one formerly middle-class woman told us in Raleigh, "we have to get rid of most of our accumulated resources, including our husbands."

In New Hampshire and New Mexico, we found families living in cars, rather than break apart to qualify for AFDC.

To require an American family to break apart to get help is meanness and punitiveness at its height. It destroys the family, by definition, and it serves to make America weaker as a result.

Another manifestation of safety net punitiveness is its no-net-gain nature. The programs, in concert, keep people in poverty. Fathers who get temporary work find their earnings deducted from their AFDC checks. Families which get a slight increase in AFDC find their food stamps decreased accordingly. Over and over families told us that, "we just can't get ahead, no matter how hard we try." What the Government adds to one pocket, it takes away from the other.

3. CONSCIOUS GOVERNMENT POLICIES KEEP POOR AMERICANS FROM GETTING HELP FOR WHICH THEY ARE ELIGIBLE

You will remember that you and your colleagues last year passed legislation to prevent the administration from using administrative practices to cut eligible people from the Supplemental Security Disability Insurance Program. This commendable congressional action did not go far enough. Similar practices are being used to prevent eligible people from getting food stamps, AFDC, and other program assistance.

In the Food Stamp Program, for example, error rate sanctions against the States make it more likely that eligible applicants will be denied assistance. State officials tell us that Federal requirements to reassess eligibility for many recipients place insurmountable obstacles before many needy people. And constant regulatory changes keep safety net programs in turmoil; computers have to be reprogrammed, regulations rewritten, workers retrained, and applicants reeducated.

As a consequence, needy and eligible applicants are prevented from getting the help they desperately need. The fact that poverty has gone up by 6 million people since 1980, but food stamp participation has gone, is a reflection of these administrative practices.

We somehow hold to the fiction that we have a safety net which reflects the compassion of the American people. But the dramatic increase in poverty, and the development of soup lines across our country stand as silent testimony to the fact that this is not true.

America has another side, and it is ugly.

Mr. Chairman, I must confess that in preparing to testify I found myself asking, "what's the use?" We know that hunger is an epidemic in America. We know that poverty is higher than at any point in the last 20 years. Reams and reams of expert testimony before committees of Congress provide ample documentation to prompt public officials to act.

Yet things get worse, not better. Hunger increases. More jobless go without unemployment benefits. More poor are without health care. Excess numbers of infants die as our infant mortality rate decline tails off.

Something is wrong in our Nation that doctors and studies cannot fix.

Somehow our highest public officials are not adequately promoting life, liberty, and the pursuit of happiness. Our people suffer, and our leaders fail to respond.

Even as I speak, poor infants are being cut from the WIC Supplemental Feeding Program in a number of States—allegedly because America has not enough money to provide needed milk for them.

Yet we somehow have $24 billion annually for tobacco subsidies. Why do we subsidize the deaths of 350,000 Americans from smoking, by denying the milk that will keep additional infants alive?

Two years ago I appeared before Senator Dole's Agriculture Subcommittee on Nutrition to report serious growth failures among poor children associated with hunger and malnutrition. I reported that unless we invested in nutrition programs, the likelihood was that I would be back the next year with further evidence of ill-health which inevitably occurs when nutrition is not adequate.

Mr. Chairman, that time has come, and my fear has come true.

I honestly do not want to return next year to have Congress ask me about our latest data. The question I have is whether our Government cares. Do rightwingers not believe that our economic system is good enough to care for all our families? Do leftwingers care as much about programs of action as they do critizing their opponents. Does Congress care enough to exercise leadership to respond to pain and suffering?

This is the central question, and Congress needs no further expert testimony to answer. And I only hope that your colleagues in the Congress will follow your leadership in doing so.

Thank you very much.

Chairman FORD. Thank you very much, Dr. Brown. At this time, the committee will recognize Dr. Harper.

STATEMENT OF GORDON HARPER, M.D., JUDGE BAKER GUIDANCE CENTER, BOSTON, MA, ON BEHALF OF THE PHYSICIAN TASK FORCE ON HUNGER IN AMERICA

Dr. HARPER. Thank you, Chairman Ford, and members of the committee. Thank you for your invitation to testify on hunger in the United States today among the recipients of public assistance. I speak as a member of a Physician Task Force on Hunger in the United States which, during 1984, conducted field visits and research into the problem of hunger throughout the country and which 2 months ago released our report, "Hunger in America: the Growing Epidemic."

This morning I will be testifying about two subjects: The findings made during our tours around the country and the impressions made during home visits this morning here in Washington. I appreciated the opportunity of joining the members of the committee on this field visit and would be glad to participate in any such visits in the future.

It is particularly appropriate to be testifying before the Subcommittee on Public Assistance, because public assistance recipients, as you know, have been among the most vulnerable to hunger. Families with the least resources, in America of the 1980's, need to be the most resourceful.

The first thing to emphasize is that the hungry are not difficult to find. Ours is the latest of some 18 studies in the past 3 years, including that of the General Accounting Office, to document a serious and growing hunger problem in this country. As a group of physicians conducting field visits around the country, we had no difficulty finding people who lacked enough to eat. In any community, you just go to the soup kitchens, you go to the Salvation

Army, you go to the churches, or you just walk down the streets in neighborhoods where live the unemployed, the elderly, or single parent families, or you visit nursery schools or kindergartens, and look at the children and talk to the teachers.

Wherever we have been, we have talked to parents who spend their entire days looking for food for their children; to unemployed men who cry as they tell us about being unable to provide for their families, and of leaving home so that their families can qualify for public assistance. To parents whose children have been taken away because they could not afford to buy them food; to elderly who scrimp on food in order to pay the gas bills or who must choose between buying their blood pressure pills and buying food. We have heard again and again of mothers with children looking for food in dumpsters. A woman has told me that when her home was broken into, the thieves took none of what are conventionally called valuable, but stole all the food. Time and again proud people told us about the cereal and eggs their children ate for breakfast, but when we looked inside the home, the kitchens and pantries were bare—literally, there was no food in the house.

We have been in homes where children were unlikely to survive the winter, with little heat and less food. And we have come to appreciate, with horror, how routine hunger becomes. In Montgomery, the day we were there, the attention of the city and briefly of the Nation, was directed to a tornado which passed through that day, killing half a dozen people. From the excess infant mortality figures for that State, we calculated that several times that number of babies die each day as a result of malnutrition. But that is not a newsworthy story. Over and over again we have heard the rationalization for stinginess, mean-spiritedness in the guise of wisdom, which would make us emotionally numb to hungry children and desperate parents. Those are anecdotes. We want statistical data. Congressmen, the hungry or failing child knows no statistics, but we do. Study after study piles up the same impression of a serious and growing problem. Yes, they may go to school without breakfast, but does it make a difference? Do they learn less well? Fellow citizens, would we ask such questions of our soldiers in the field, or our astronauts in space, or our pilots in the air, or our representatives in Congress? If we heard that our own children, yours and mine, were going to school without breakfast, would we wait for data about impaired academic performance before feeding them? Of course we would not. We would act at once. Not to act as swiftly on behalf of all the children of our Nation is to selectively discriminate against the poor or the needy.

Yes, they may be hungry, but they have to learn how to spend their food money more wisely. Nutrition education has a place, no doubt about it. But talk about nutrition education too often is used to blame the victim and to excuse public inaction in the face of urgent human need. Moreover, it is just not that simple. I have seen families coping with shortages of food and surpluses of paperwork which would daunt my family and yours.

Yes, they may be hungry, but it is largely a problem of welfare mothers, teen-age mothers, babies born out of wedlock, and former mental patients. These code words are heard again and again. We must beware of them. They suggest—I think intentionally—that if

the poor lived as the speaker thinks they should, or if the ill were cared for, there would be no problem. Such remarks betray an ugly paternalism and exaggerates the peace among the hungry or ex-mental patients. But apart from that, do we really want to visit on the bodies of the young nutritional penalties for their parents life-styles?

Yes, they may be hungry, but we have to look at national priorities, balancing the budget, strengthening our defense. As Americans, is there any investment we make in the future which matters more than the health of our young?

Now, these rationalizations and politically motivated ignorances must be identified and scotched because we are in the midst of a hunger crisis. Anyone doubting this need only travel as we did this morning, with members of the committee, to the Johnson home on Sherman Avenue, only a few miles from this Capitol. Here is a seven member family, embracing four generations, ranging in age from an 11-month-old baby girl to a 92-year-old "great godmother." The baby's young mother, her school-age siblings, and their mother complete the household. They were introduced to us as a family with a feeding problem. The 11-month-old is underweight, a case of failure to thrive, which is medical jargon for a child who fails to grow as expected. The team at the Comprehensive Health Care Clinic on 11th Street, NW—doctors, nurses, social workers, nutritionists—had helped them medically and with supplemental food through the Women, Infant 7and Children [WIC] Program. Yet the baby still fails to grow. Born weighing 6½ pounds, she now, a month short of her first birthday, weighs only 13 pounds, 6 pounds below her expected weight. She weighs, in short, about two-thirds of what she should. In addition, we were told, she is anemic.

She is a handsome child, well formed and well cared for, with her hair in neat corn rows. But she is small and has thin arms and legs. She sat alertly on her mother's knee, rather quietly, and failed to reach for a proffered pen as a better nourished 1-year-old might, but reached eagerly for the 90-year-old woman when she hobbled into the room.

Now the team wondered, was this psychosocial failure to thrive? That is, was this baby failing to grow because of emotional deprivation? Her bright eyes and eager attachment to mother and great godmother indicated that is not the case. Is she simply not getting enough to eat? What are they living on? This family of seven lives on $630 per month, $390 from AFDC, $240 from food stamps. How do they fare? They said, rather bravely I felt, that, yes, it was difficult, but that they made it most months, frequently only with gifts of food from friends or donations from churches. But they found it hard—I think their pride got in the way—to recall a month when they had actually run out of food. On the other hand, they appeared defensive. The baby's grandmother did not want the old woman to tell about the days when she had nothing to eat while living alone.

Had we heard that the whole story? In this work you learn to work in the kitchen. We asked to see it, and there it was clear why they were defensive. This was the food that was there; in the refrigerator, a few nearly empty pans—perhaps they had the traces of stew in them, and on the pantry shelf a small package of maca-

roni. This was all, for a family of seven, including a baby and two school-age children. No milk, butter, cheese. No vegetables. No bread, no cereal. None of the Similac, let alone Similac with iron which the baby was said to be eating. My body twinged as I stood and looked at the empty larder.

Here was the explanation for the failure to thrive. Here was the explanation for the anemia. Here was the explanation which had eluded the clinic based staff, this family was living on the margin of starvation, and the baby, the nutritionally most vulnerable member of the family, was over the edge.

And I remind you a child is 11 months old only once. There is no turning back the developmental clock.

How does one respond to a situation like this? The Congressmen spoke with one voice, after the visit standing on the sidewalk outside the house. "You can discuss programs and budgets in the Congress but it is all conceptual. When you visit a family like this, it is a different story. I feel changed as a Congressman and as a person by this visit."

Where is the recovery, America? Where is the safety net? Where is the wisecrack about the "Welfare Queen" or the derogating remarks about anecdotal data which will make the visit to the Johnson home go away?

I do not know. Thank you for the opportunity to testify.

Chairman FORD. Thank you very much Dr. Harper.

At this time the committee will recognize Dr. William Beardslee, clinical director for the Department of Psychiatry at the Children's Hospital in Boston, MA.

STATEMENT OF WILLIAM BEARDSLEE, M.D., CLINICAL DIRECTOR, DEPARTMENT OF PSYCHIATRY, CHILDREN'S HOSPITAL MEDICAL CENTER, BOSTON, MA

Dr. BEARDSLEE. Thank you very much. I commend you for your visit this morning and I think field visits are essential in understanding these problems. I have been asked by Dr. Brown to provide a historical perspective, because I was a member of the tenth year review of hunger by the Field Foundation in 1977, and also was active in Mississippi in 1966 and 1967 when the first team of physicians supported by the Ford Foundation visited there, although I was not a physician myself at that time.

I want to cover very briefly four areas today. The first is the immense human suffering caused by hunger. The second is a contrast between Mississippi in 1977 and now, specifically Greenwood, MS. The third is a contrast between two kinds of Federal programs in terms of administration, one of which I think, is extremely successful, and the other of which leaves a great deal to be desired. One is the Head Start Program and the other is the Food Stamp Program. Fourth, as a doctor and psychiatrist, I would like to talk a little about the hidden cost of hunger.

In terms of the immense amount of human suffering caused by hunger, it occurs now, daily. It is linked to other aspects of poverty and discrimination. It is immense, no matter how measured, whether in the increase of the requests for free meals from various churches, soup kitchens, and so forth, whether in the millions who

have fallen below the poverty level since 1980, whether in the increase in requests for assistance to the Federal Government, or whether in the variety of studies documented in our report from areas all across the country. Above all, one can see the immense cost of the human suffering caused by hunger in the lives and faces of those who are hungry. When, as members of the task force have done, you go into homes, when you go into schools, when you talk to children, parents, you see the cost of hunger in the faces. You see it, as Dr. Harper says, in people's shame, in their trying to cover up, and in their suffering. I think it is very hard to quantify this, to put a number on it. I insist that it is real and it is apparent and none of us can walk away from a field visit, from seeing it, without being changed by it.

I have been in the Northeast with the physicians' task force; I have been in Mississippi; and I have been in the Southwest. That's not all of the country, but it is several different regions of the country. We have seen the same things, in all the regions, an immense cost from going hungry on a daily basis.

I want to talk a little bit about Mississippi as an illustration of what I think is happening across the country. I think we can dismiss poor people in the South and people in minority groups unfairly, by saying they are not representative of the country. Mississippi is one of the poorest States, and it has a large minority population. I am talking about Mississippi, however, as a place where we see clearly what is going on in all of the country. We can see patterns for the whole country very clearly there. In 1967 there was some starvation among children in Mississippi, and serious documented malnutrition. Largely because of the attention focused on Mississippi there was a profound Federal response in terms of increased assistance in a variety of food, health and other programs.

When the Field Foundation task force returned to Mississippi in 1977, we saw dramatic changes for those people who were served by the programs, particularly Head Start and some of the food assistance programs. The youngsters were certainly no longer starving. There was much less malnutrition. Also, and I think this is an essential part of all of this, there also was the sense that problems could be tackled and addressed, that change was possible. Because of individual action, change in individual lives was possible and also change through governmental action, the Government could take action and do something. People who worked in Head Start, and other programs had that feeling, and that had a large and positive effect on the community as a whole. It is interesting that we held hearings on the identical meeting place in Greenwood, MS, both in 1977 and in 1984, and visited some of the same areas.

In 1984 we were there in May. Things are very different. Programs that have survived like the Head Start, continue to render great service to those who are enrolled, but there are many, many children who are eligible, but are not enrolled, who are just as needy. With the Food Stamp Program there has been a marked change, starting, I believe, around 1980. There is much more just plain bureaucratic redtape and meanness that has made both access to food stamps and the getting of food stamps a very difficult and a very humiliating experience. The people themselves talk

about a sense of being abandoned by their Government, of being abandoned and, furthermore, they talk with a sense of hopelessness, of not making it day-to-day, of having no sense of possibility of breaking out of the cycle of poverty, of having no chance of changing their lives. I think it important that we not ignore the human dimension of faith in one's own capacity to change things, and also faith that the efforts of one by one's self will be met by a government, or an educational system, with support and attention. That faith is exactly what is breaking down in Mississippi today, and I think in places all across the country.

That is the contrast then between 1977 and now, and it is not simply in the increase in the number of people who are going hungry, although that is very substantial and tremendously important, but also in the loss of faith or hope or perhaps a sense of will, in Congressman Leland's terms, I emphasize again that I think Mississippi allows us to see more clearly what is going on across this country and to dismiss it as a kind of isolated, very poor State with a particular kind of agricultural system, and so forth, would be a profound mistake.

Now to my third main point, the contrast between two kinds of Federal programs, Head Start and Food Stamps. I talk about these both as a person who has been observing them for a number of years in my work, and also as a doctor who is on the task force and who has talked to the recipients at length about them. I think one of the essential things that is important to recognize about the Head Start Program is that it is, and it was from the beginning, aimed at really trying to change the lives of the children and families who enrolled in it. Everything that was done was done to realize this aim. Therefore, there was the provision of counseling about child development. Therefore, there was training designed to help people so they could realize their own dignity as parents and help themselves. Furthermore, it tied into a basic felt need of all of us to raise healthy children for the future. Poor people are no different than the rest of us in this regard.

Finally, the new Head Start was organized, on democratic principles, with community representation on its boards, and with the provision of some jobs for the community as teachers aids, and so forth, reflected its fundamantal aim, and contributed to it.

Though we are not here to talk about Head Start, I will say that both by the rigorous scientific evaluation in academic centers, and by the evaluations of field visits, it is an immensely successful program. It is also in part a feeding program, and make no mistake about it. Many children receive both breakfast and lunch in Head Start, and many children receive the only good meals of the week in the Head Start program.

To contrast the Food Stamp Program, one of the things we did on the field visits was to go and talk to the people in the food stamp offices. We also talked to the recipients. Both sets of people said there have been dramatic changes in this program. The feeling of bureaucratic meanness, of withholding, of denying, of putting down the recipients, has come to pervade the program. That is not the way to help people and break the cycle of poverty.

In Houston, I talked to a young worker in a food stamp office. She said: "We were told a few years ago to go out and do outreach.

We have been told now not to do that, but to cut back on the number of people that we can allow on the rolls." As another example, in the last 3 years there have been over 25 changes in the regulations that recipients must meet. Try to think about anything that any of us do that has 25 different changes in regulations, and we are all educated people. A lot of people, poor folks, cannot read, yet must understand and meet the regulations. We have joked about this, but a number of people have stated that requirements for being on food stamps are more complex than filling out a 1040 tax form. It doesn't make sense. The complexity of the regulations penalize, further limits, and hinders the very aims of the program.

Finally, again, the program doesn't use people in the community who know where the hungry people are, who know who the people in need are, to find people, or assist them in getting food stamps. Instead, we have bureaucrats sitting in offices, not outreach. There are no community boards. There are no local people hired and trained. There are also difficulties in transportation in both rural and urban areas without outreach. We have heard stories of the other people getting $35 a month for food stamps, but it costs them $10 to get driven into town and back, from their rural place of living. It just is a system that can be improved dramatically.

I think that is a bit about the differences between programs, but I think it is very relevant to your committee because, again, if you look at AFDC, and see that in 27 States there are requirements that the father in a family cannot be in the home if the family is to qualify for AFDC, you see another program defeating itself, breaking people's families and breaking morale, rather than using Government programs to support morale, strengthen families, and break the cycle of poverty.

I could have illustrated the contrast with the WIC programs which are successful. I chose Head Start because I work with children, and because of my experience with it over 15 years.

Now, to the cost of hunger, the hidden costs of hunger. I think that when a child goes to school hungry, the child loses that day. It is a lost day. The sensation of hunger, the need for food dominates that child's consciousness. How many days are lost—for some children, a few days a month; for some children, 100 days a year, so that although these children may or may not show up on the growth charts as falling below the expected curve, or as not having a diagnosable disease of hunger, they lose their education and they lose in many other ways. In terms of peer relationships, we heard a heart rending story from a teacher in Rhode Island who said when the kids are young, in the primary grades, and they come to school and are hungry, they will steal food from the other children's lunchboxes. The response of these other kids is to share and, to make available what they have.

In high school when that happens the response is very, very different. Kids are angry and fight. This is an example of the effect of hunger on peer relationships, violence between kids that perhaps doesn't show up as a statistic, but the illustration gives, again, some sense of the hidden cost of hunger. Finally, I think that each of us has to ask ourselves what kind of a sense of America are we giving to children who are hungry? We are giving them the sense of the world and America as unstable, uncertain, unreliable. Cer-

tainly there are many factors in growing up poor and growing up in various kinds of disadvantage that can contribute to a sense of unstability and uncertainty, but hunger is an important one. From the family perspective think of what it is like for a parent to try to tell a child, I do not have enough to feed you. What that does to all the processes of respect for parents and family we are trying to foster. Many, many times the answer is, of course, that the mother denies or the father denies himself food, feeds the child, and then is exhausted and defeated himself or herself. This is not a cycle that we want to foster, nor can we afford to.

Finally, I think that these forces do occur in our young people who are hungry, they lose faith in their parents and their country. I am seeing more despair now than in the past, and I think that robs us as a country of the contribution of those who despair, and it is an immense cost.

Those who sow the wind reap the whirlwind. We are sowing the wind in allowing a generation to grow up hungry.

As a physician, I am used to wrestling with problems that do not have an easy solution, with diseases without cure. When I come to the problem of hunger, I am enraged because we know how to eliminate it. We know how to cure it, and we came close before, in the late 1970's. There is no reason for these hidden costs of hunger and waste of human lives that exist today because of hunger.

Thank you very much.

Chairman FORD. Thank you very much. The committee calls on Dr. Sam Shapiro, professor of health policy and management, Johns Hopkins University, Baltimore, MD.

STATEMENT OF SAM SHAPIRO, PROFESSOR OF HEALTH POLICY AND MANAGEMENT, JOHNS HOPKINS SCHOOL OF HYGIENE AND PUBLIC HEALTH

Mr. SHAPIRO. Congressman Ford, before I start with my prepared statement I do want to express my regrets, at not having been available this morning to join you on your site visit. My expertise is in epidemiology and biostatistics and I deal with research and generate numbers. But I do want you to understand, that I know there are people behind those numbers and that many of the statements we have heard today illustrate very importantly the implications of the data that are available.

At this point I want to move directly to a presentation of information on changes that have occurred in the infant mortality rate in the United States.

Interest in infant mortality is high because of its importance as a barometer of health status on a national and local level, and in different subgroups of the population. It is a sensitive indicator of the effect of changes and differences in social and economic conditions and medical care, and it is closely watched. Fortunately, through the data on births and deaths published by the National Center for Health Statistics, information is available on long term trends in infant mortality and on the changes that are currently underway.

Figure 1 illustrates the major reductions in infant mortality that followed a fairly static situation during the 1950's and early 1960's. Between 1950 and 1965, the average annual percent decrease was

only 1 percent compared with an annual average of 3.2 percent between 1965 and 1982 when the rate reached 11.2 percent per 1,000, less than half the rate of 24.7 percent per 1,000 in 1965. The only cloud in this otherwise bright picture of a sharp downward trend in the overall infant mortality rate is that since 1982, there has been a slowdown in the decline.

Here is the situation. From 1965 to 1982, the smallest year to year absolute decrease in the rate was 0.3 percent per 1,000—1977 to 1978; provisional figures show that a similar small change occurred in 1983 and 1984. This may be a temporary slowdown and the downward trend may once again become steep. But, the fact that it has persisted for 2 years is cause for concern.

As seen in table 1, the downward trend in infant mortality in the United States was not an isolated achievement. It is consistent with a pattern of improvement in many industrialized countries, in several of which the rate has fallen far below 10 percent per 1,000. The important point is that low mortality countries with varied social and ethnic populations and health care systems have kept pace with each other in recent years in reduction in infant mortality. Further, the levels their rates have reached should dispel any notion that we are even close to an irreducible minimum.

Table 2 shows that a characteristic of the reductions in infant mortality since the mid-1960's is that large decreases occurred both in the neonatal period—under 28 days after birth—when prenatal and intrapartum factors predominate as risk factors and in the postneonatal period—the balance of the first year of life—when mortality is affected mainly by environmental conditions present after the infant is discharged from the hospital. Closer examination of what happened is that the decrease in the neonatal mortality rate accelerated during the 1970's, a circumstance traceable, in part, to the diffusion of advances in perinatal care, including neonatal intensive care units and regionalization of care for high risk pregnancies. Additional decreases have taken place during the 1980's. On the other hand, since 1982, there has been no decline in the postneonatal mortality rate and as far as we can tell from the provisional data some increase has occurred.

Table 3 indicates that infant mortality among white and black infants dropped markedly after 1965. It is clear that in both the racial groups the rate was cut in half by 1981.

Information is not yet available for the United States to see whether the slowdown is affecting the two racial groups, differentially, or in a similar way. But, we can expect that the infant mortality rate is still twice as high among black infants and that it is at the same level as the white rate 15 years earlier.

No discussion of the infant mortality rate is complete without consideration of the low birth weight rate, that is, the proportion of infants weighing 2,500 grams or less—5½ lbs.—at birth. A comprehensive report on the subject, titled "Preventing Low Birth Weight" has recently been published by the Institute of Medicine, National Academy of Sciences. The report was prepared by a committee, of which I was a member, consisting of individuals from the fields of obstetrics, pediatrics, epidemiology, and health economics. I will only touch on a few of the findings and conclusions that are particularly relevant for this subcommittee's hearings.

In 1981, 6.8 percent of the newborn had low birth weights, a group that accounted for two-thirds of the deaths in the neonatal period and 20 percent of the postneonatal deaths.

Every available indicator of disadvantaged social and economic status was associated with relatively high low birth weight rates. This includes births to teenagers and to women with less than high school education in both racial groups; also, births to women who started prenatal care after the first trimester of pregnancy.

A major conclusion was that significant decreases in low birth weight are an imperative to achieve future reductions in infant mortality and to reduce the extraordinarily large expenditures in saving the lives of low birth weight infants, especially the very small babies, and in providing care for the survivors.

Many factors will have to be involved in reducing low-birth weight but of special interest is the following conclusion in the Institute of Medicine Report:

> The Committee urges that nutrition supplementation programs such as WIC be a part of comprehensive strategies to reduce the incidence of low birth weight among high risk women. Such programs should be closely linked to prenatal care.

This statement was based on a careful review of many studies which support the overall conclusion "that the WIC Program provides positive benefits to nutritionally and financially high risk pregnant women."

In summary, infant mortality decreased sharply from the mid-1960's to the very early 1980's. We cannot partition precisely the credit for the improvement among changes in the environment, nutritional status, the economy, and medical care. However, all must have played a significant role. In the past 2 years, 1982–84, the decline in the infant mortality rate has slowed down.

The special interest is that the slowdown, even though for only 2 years, follows on the heels of an economic recession and a change in Government funding for social programs. A leveling off of the infant mortality rate need not be seen as part of a natural course following large decreases. Other countries have reached lower levels than the United States and past experience suggests that lower levels elsewhere indicate achievable levels here.

Experts are pointing out that reductions in the low birth weight rate are needed to achieve significant decreases in infant mortality and reduce the differential between high and low risk population groups. Such reductions would have the added benefit of decreasing costly medical care. Nutrition supplementation programs, including WIC, coupled with early prenatal care are strongly advocated for this purpose and measures to shore up these programs are essential.

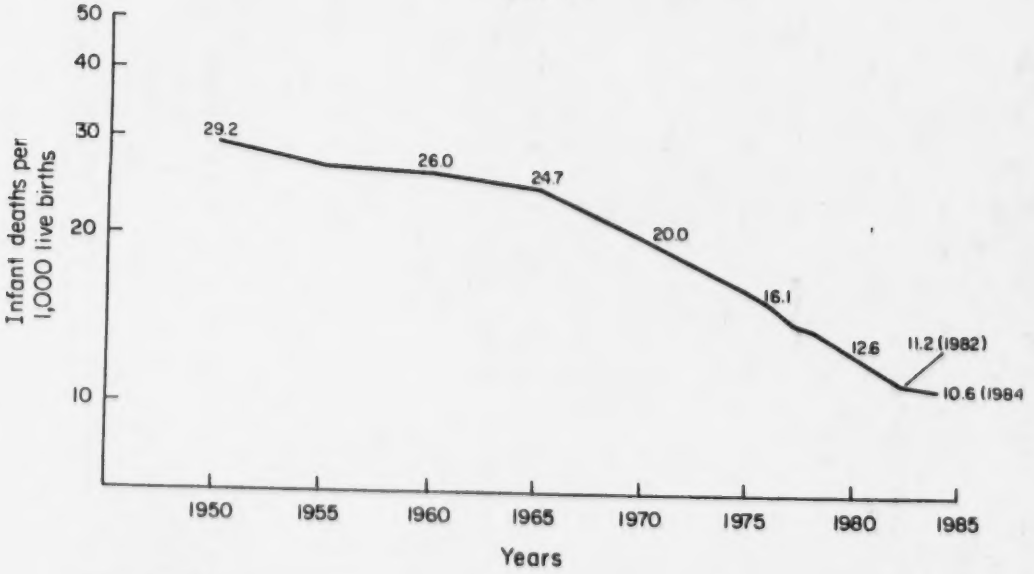
[Attachments to the prepared statement follow:]

Figure 1

INFANT MORTALITY RATES

UNITED STATES

1950-84



Source: See Table 2

TABLE 1.—INFANT MORTALITY RATES AND AVERAGE ANNUAL PERCENT CHANGE: SELECTED COUNTRIES, 1976 AND 1981

Country	Infant mortality rate		Average annual percent change[2]
	1976	1981[1]	
Sweden	8.3	7.0	−3.3
Japan	9.3	7.1	−5.3
Finland	9.9	7.6	−6.4
Norway	10.5	8.1	−6.3
Netherlands	10.7	8.2	−5.2
Denmark	10.2	8.4	−4.7
Switzerland	10.7	8.5	−7.4
France	12.5	9.6	−5.1
Canada	13.5	10.9	−6.9
Australia	13.8	11.0	−5.5
Belgium	15.3	11.7	−5.2
New Zealand	14.0	11.7	−3.5
United States	15.2	11.9	−4.8
United Kingdom	14.5	12.1	−4.4
German Democratic Republic	13.9	12.3	−2.4
Austria	18.2	12.6	−7.1
Federal Republic of Germany	17.4	12.6	−7.8
Italy	19.5	14.3	−7.5

[1] Data for Switzerland and Canada are for 1979. Data for Finland, Norway, Denmark, Australia, United Kingdom, Federal Republic of Germany are for 1980. Data for all other countries refer to 1981; of these the U.S. figure is final and all others are provisional.
[2] Average annual percent change is between 1976 and the most recent year data are available.

Sources: United Nations: "Demographic Yearbook, 1980 and 1981." United Nations, 1980 and 1983. National Center for Health Statistics: Advance Report of Final Mortality Statistics, 1981, "Monthly Vital Statistics Report," Vol. 33, No. 3, DHHS Publ. No. (PHS) 84-1120. Public Health Service, Hyattsville, MD, June 21, 1984. Countries selected from table 14, Health, United States, 1984, U.S. DHHS, Public Health Service.

TABLE 2.—INFANT, NEONATAL AND POSTNEONATAL MORTALITY RATES AND AVERAGE ANNUAL DECREASE, UNITED STATES 1960–84

	Infant deaths per 1,000 live births		
	Total	Neonatal (under 28 days)	Postneonatal (28 days–11 months)
1960	26.0	18.7	7.3
1965	24.7	17.7	7.0
1970	20.0	15.1	4.9
1975	16.1	11.6	4.5
1980	12.6	8.5	4.1
1981	11.9	8.0	3.9
1982[1]	11.2	7.6	3.6
1983[1]	10.9	7.3	3.6
1984[1]	10.6	[2] 6.8	[2] 3.8
Average annual decrease (percent):			
1960–65	1.0	1.1	.8
1965–70	3.8	2.9	6.0
1970–75	3.9	4.6	1.6
1975–80	4.3	5.3	1.8
1980–82	5.6	5.3	6.1
1982–84	2.7	5.3	[3] 2.8

[1] Provisional data.
[2] 12 months ending with November 1984.
[3] Increase.

Source: Health, United States, 1984, U.S. Department of Health and Human Services, Public Health Service, for years 1960–83, Monthly Vital Statistics Report, annual summary of births, deaths, marriages, and divorces, United States for 1984, National Center for Health Statistics.

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TABLE 3.—INFANT MORTALITY RATES BY RACE AND RATIOS BETWEEN BLACK AND WHITE RACES UNITED STATES, 1965–81

	Infant mortality rates		
	White	Black	Black/white
1965	21.5	41.7	1.94
1970	17.8	32.6	1.83
1975	14.2	26.2	1.85
1980	11.0	21.4	1.95
1981	10.5	20.0	1.90

Source: Health, United States, 1984, U.S. Department of Health and Human Services, Public Health Services.

Chairman FORD. Thank you very much, Dr. Shapiro.

The committee would like to thank you, Dr. Brown, Dr. Beardslee, and Dr. Harper, as well. Thank you Dr. Harper and Dr. Brown in joining with us once again on the field trip.

Mr. Brown, in your testimony you talked about the failure of Congress and the American public to recognize the real growing problem of hunger in America, and you talked about failing to respond or do something about it.

Why do you think this happened? Why do you think that we have seen, from the assistance bureau, the General Accounting Office, we have seen reports from the Congressional Budget Office, we have seen reports from the Congressional Research Services, anyway, about four Federal entities, you know, have all said in their data that they have released to the Congress and the American public, that poverty has increased to a total of about 35 million who live at or below poverty. We have had an increase of poverty in the last 4 or 5 years, and if poverty continues to increase you have indicated that we might be approaching the epidemic stages of hunger in this Nation.

Why do you think it happened? Some reports have talked about the policies of this administration. I am sure we had hunger in America prior to the 1981 reconciliation. Why do you think it happened? Let me hear from those who worked long and hard and completed the study on hunger in America. Tell the committee why you think it happened?

Mr. BROWN. Congressman Ford, the evidence basically indicates that three factors came into play during a several year period, which lead or ushered in the return of hunger to the Nation. The first factor is that America's safety net compared to other industrialized nations in the world is very, very weak. I meant it when I said a Band-Aid. It was extremely weak and it got weaker from, say the mid-1970's on. For example, the basic program for poor people, of course, is AFDC, for those who can get it. AFDC benefits failed to keep up with the cost of living and so from 1970 until 1984, on a national average, AFDC families lost 33 percent in purchasing power. Food stamp households lost 18 percent. There are also other examples, but those are just two.

The point is that an already weak safety net was getting more tattered. There are also other indices by which we can look at how well we do. There is no evidence that any other industrialized nation has the hunger problem we do. There are only two industrialized nations in the world that do not have a system of national

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health insurance. The other country is South Africa. Second, of course, the economy went bad; and because of some cutbacks, and because of general economic conditions, policies, and so on, poverty began to go up rather dramatically. It is at the highest rate now in 20 years, so that both of these factors together indicated that need in America among American families was going up quite dramatically.

Chairman FORD. We hear that America is back. Things have worked out now. We are out of the recession, the economy is in good shape, according to the Chief Executive. Things are getting better. The economy is strong again.

Mr. BROWN. Let me tell you what we found with respect to that. The third reason we think that the hunger returned, as the need was peaking in our country, is that we instituted the sharpest budget cuts in our history so that families who had been living at the economic margin for years, just getting by, literally had the floor knocked out from under them, and those are the people we find in the bread lines of our Nation. We can see the etiology, we can look at the causes of it in other words, and we can see that beginning in about 1979, during 1980, we saw the beginnings of soup lines in America. What happened was with these immense cuts in nutrition programs, as need was going up, the hunger problems simply proliferated immensely. When we were out, one of the things that astounded us was why hunger was increasing when there were reported improvements in the economy. But we found we were asking the wrong questions. We should not be asking is the economy improving because there are improvements. We should have asked for whom the economy is improving.

The best way to depict this is the report of the nonpartisan urban institute, which shows from 1980 to 1984, the bottom two quintiles, the bottom 40 percent of the U.S. population lost in purchasing power during that 4-year period. So the people who are recovering were not in any danger to begin with, and the people who are in danger as of yet show no signs of recovery.

Chairman FORD. Dr. Brown, and other members who would like to respond to this, what can we do at this point to reverse the trend?

Mr. BROWN. I will answer with two sentences and let my colleagues respond. Basically, we do not think that we have to set up new bureaucracies, new programs, whatever. We have nutrition programs in this Nation which worked and which worked very well. Do they need to be altered somewhat? Yes. Food stamps need to be seen as a health program rather than a welfare program. That is a lesson that one can learn by looking at support among the American public, and the Congress. Hunger returned because these programs were weakened when we needed them the most, and we need to strengthen those programs.

Chairman FORD. Dr. Harper.

Dr. HARPER. I would respond in terms of what I see as a neglected responsibility on the part of the Congress. In the early 1980's there was a lot of discussion about the extent to which Federal programs were needed and there was a strong movement to dismantle the programs. I think what happened was that both the administration and the Congress neglected to take responsibility for sur-

veying what would life be like then without the programs. It was as if the fellow on the bottom of the pyramid was told that he could go out and take a coffee break, and not worry about the rest of the people above. Or as if we told people who support a family, now you can go to Hawaii and do not worry about who you left behind. The point is, there are a lot of programs which Congress set up, which were making a difference to some degree in human life, and along with the dismantling of programs, we have not had a systematic assessment of their effects. The fact that we are having hearings today on this subject is a result of that, and we can make a comparison.

When deregulation was effected in the airlines, there has been no shortage of data describing exactly what the effects of that have been. Anybody can tell you right today how many routes there are compared to before deregulation, what the effect on prices have been, how many people arrived before. We do not have this data in regard to the social programs that have been dismantled in the 1980's. We need them.

Chairman FORD. Mr. Matsui——

Dr. BEARDSLEE. I was just going to add that I think there is a myth which is that somehow that many of these social programs were ineffective. They were not, and are not, and as I said in my testimony, I think that we need to strengthen the programs that we have and we can learn from some of the most effective ones in devising strategies to strengthen others. As you have suggested, we could make food supplements part of the health system rather than the welfare system.

Chairman FORD. Mr. Matsui.

Mr. MATSUI. Dr. Harper, how did we help the people that we had visited with today? We are told that there is a cycle, you know, the mother—the 35-year-old mother—the 17-year-old daughter, and now you have a 1-year-old child, and there were a few other children as well. How do you break that cycle of dependency that appeared to be the situation?

Dr. HARPER. Discussing it from a clinical point of view, the group that took us there were really not clear about what the diagnosis was. I do not think they appreciated, because they had taken an oral nutritional history from the family members, just how little food the people had. Here, in clinics in Washington, as well as elsewhere, people do not like to acknowledge that they do not have enough to feed their children and I think that now that that is clear, the task is to get adequate food to this child and see what her growth potential is and then find a way to deliver it to home. From a policy question, I would respond to the question about the cycles of dependency in terms of the Head Start Program that Dr. Beardslee referred to before. To visit poor communities where Head Start is working is an experience which every Member of Congress should have just as every physician should have, particularly to visit communities of comparable socioeconomic status which have and do not have Head Start programs and see the difference in the children, see the difference in the parents. See the element of hope as it enters community life.

It is a program which does so much both for children and for families that I think it deserves greater support from Congress,

and for me, it would be a centerpiece to any program addressing the intergenerational dependency pattern. I had mentioned, I think, only about 15 or 20 percent nationwide of Head Start eligible children are actually in the Head Start Program. That means that 80 to 85 percent are not.

Mr. MATSUI. Mr. Chairman, did you want to recess or end the hearing?

Chairman FORD. We will let you go for another 4 or 5 minutes, if you would like.

Mr. MATSUI. I do not have any more questions. The only thing I would like to discuss, and you may want to submit something in writing, is the book "Losing Ground" by Charles Murray. It seems to have gotten a lot of attention lately. In fact, one of my friends in Sacramento, CA, was very impressed with it. Could you comment on that? Any one of you because it seems that that book and that philosophy behind it, which is getting some prominence now, is part of the whole generation, I suppose. Could you comment on that?

Mr. BROWN. Congressman, I will be happy to respond in more detail on the book itself, although I can tell you that from having read it, as well as colleagues of mine who look at it from a policy perspective, I am not terribly impressed with the methodology and thinly veiled political orientation of that analysis. I think the interesting thing, however, is that the conservatives and Republicans can perhaps come together around the agreed upon concept that we have to promote independence and integrity of American families, both of those things together, and that we do not really want to promote dependence.

Now, the so-called conservatives will say that welfare promotes dependence and we should do something rather than welfare. Liberals will say that we also have to promote independence, but we cannot do it by making people so dependent on programs that they are on so they can never get on their feet anyway. There is room there, it seems to me, for beginning to talk the same language, and the first thing that has to be done is talk about what we mean by dependence and independence. There can be no equivocating on the fact that we cannot make any family in America, by and large speaking, independent by keeping them in a situation where they cannot get jobs, where they cannot bring together the integrity of the family and hold it together through economic stability.

There are only two ways that I know of to help families: give them jobs so they can support themselves or give them assistance while they do not have jobs in sufficient quantities and in ways which enable them eventually to get those jobs.

And we dicker around and we play around the edges with that, but that is the fundamental issue, it seems to me, where conservatives and so-called liberals are going to have to come together and eventually talk the same language.

Dr. HARPER. It seems to me that Congress is unnecessarily in a weak position here; that is, we should have much stronger data on the effects of Government programs than we have. We need a family impact system, family impact which was a surveillance system comparable to our environmental impact program, one of Senator Moynihan's proposals in his Godkin lectures at Harvard a

couple of weeks ago. We have scattered data like this with regard to Head Start. We have a 20-year followup on the efficacy of Head Start. We have short-term followup on programs like the Job Corps. We are dependent as citizens on politicized and sensationalized efforts to pull data together. Like the Murray book you referred to, we should not be so dependent on unsystematic doctors. This is not to say that there is a kind of a technology that is going to answer all questions of policy. It will not. There will always be questions of policy that depend on assessment of values and priorities, but there are data questions here about the effects of providing services in one form or another which the Congress should have access to.

Chairman FORD. It was a great experience for the chairman of the subcommittee today and I hope it was the same type of experience for the other subcommittee members. I speak on behalf of the committee that we do appreciate the four of you and the members who took time out of their busy schedules for this morning.

I do have some additional questions that I would like to submit to you and the panel and, if you do not mind, submit them back for the record.

Congressman Leland had to leave, and there were nine questions that he wanted to submit to the panel, and we hope that you will all submit responses to his questions for the record.

[The questions and answers follow:]

SUBCOMMITTEE ON PUBLIC ASSISTANCE AND UNEMPLOYMENT COMPENSATION,
Washington, DC, May 13, 1985.

J. LARRY BROWN, Ph.D.,
Chairman, Physician Task Force on Hunger in America and Harvard University School of Public Health, Boston, MA.

DEAR DR. BROWN: I would like to once again thank you for your testimony at our April 30, 1985 hearing on the growth of poverty and hunger in America. Several members of the Subcommittee found the field investigation approach, pioneered first by the Physician Task Force on Hunger in America, to be a particularly fruitful way to learn about the problems of poor children in this country. I hope you will also share my appreciation with the other doctors who took part in the field visits and hearing.

Enclosed are a number of questions to which I would like you to respond for the record of the hearing. In some cases it may be more appropriate for other members of the panel to supply the response to a question. I would ask that you coordinate obtaining the responses of your colleagues when this is the case. Included are a series of questions which time did not permit me to ask as well as a number of detailed questions which Mr. Leland has submitted.

Should you have any questions or need additional information, please do not hesitate to contact the Subcommittee staff [(202) 225–1025].

Sincerely,

HAROLD FORD, *Chairman.*

QUESTIONS FOR THE RECORD FROM MR. FORD

1. Just prior to the hearing, we visited a health care clinic and a social service center and talked with clients and staff. Several of you also joined us for home visits.

Were the people we talked to and the families we visited with typical of those you met as you traveled across the country?

How often did you find families who go without food at least several days per month?

2. What can this Subcommittee—which has jurisdiction over AFDC and unemployment compensation among other programs—do to help reverse growing pvoerty and hunger?

3. Many of the children you have seen as you traveled across the country are growing up without adequate nutrition, shelter and health care.

How will this affect their ability to grow and become productive citizens in the future?

4. In the Task Force report, you note that the punitive nature of many public assistance programs deters people from applying for assistance. Obviously, some requirements are necessary to assure that only eligible families participate.

How do these programs actually deter people from participating?

Are there specific policies that need to be changed?

QUESTIONS FROM REP. MICKEY LELAND

General

1. It has been noted in your report that hunger is the result of Federal government policies. I have had an opportunity to review the changes you have recommended in federal policies to restrain the growing hunger epidemic. Many of us in Congress are now involved in a difficult battle to secure adequate funding for our domestic feeding programs. I, of course agree with your recommendations. However, I am not optimistic that we will see such far-reaching changes in programs this year. In your estimation which of your recommendations are most vital for us to push for this year? More clearly, what are your goals for fiscal year 1986?

2. We know that inadequate funding for WIC is the cause of under participation in that particular program. What major factors do you find to be responsible for under participation in the Food Stamp and other Federal aid programs?

3. Are the elderly more under represented among participants of these programs? If so, what have you found to be the cause of high non-participation among this group?

Medical

4. One newspaper account of your study notes that a Cook County hospital official was quoted as saying that he saw 15 to 20 cases of kwashiorkor and marasmus every year. Did you receive reports about the existence of these maladies in other areas of the country?

5. Your report cites that hunger in America is a public health epidemic. Would you cite some of the health consequences of hunger which are appearing in epidemic proportions?

6. Malnutrition is probably the most under diagnosed health problem. To what do you attribute this—for lack of a better word—oversight? What suggestion do you have for placing more emphasis on diagnosing malnutrition?

7. Can you describe for us the illnesses you see in your practice which are direct correlates of hunger?

8. What seem to be the major nutrient deficiencies found among low-income people?

9. Your report indicates that approximately 20 million people in this country periodically go without food. Can you describe what type of health impact—both short and long term—these periods of hunger or undernutrition have on children? What about the elderly?

PHYSICIAN TASK FORCE ON HUNGER IN AMERICA,
June 14, 1985.

Hon. HAROLD FORD,
Subcommittee on Public Assistance and Unemployment Compensation, House of Representatives, Washington, DC.

DEAR CONGRESSMAN FORD: Enclosed are my responses to the questions posed by you and Congressman Leland following my testimony before your Subcommittee.

I am very glad to hear from you that members of the Subcommittee found the field visits worthwhile. We share your sense that direct contact with poor families and the agencies that serve them is an invaluable way to learn about the problems of the poor. The physicians who met with you on April 30th, in both the field visits and the hearing, appreciated your obvious concern for the issues we have been addressing.

If there is any further information I can provide please be in touch. I look forward to continued discussion and collaboration in the future.

Sincerely,

J. LARRY BROWN.

Enclosure.

RESPONSES TO REPRESENTATIVE FORD'S QUESTIONS

1. a. In general the conditions revealed in Washington, D.C. visits were similar to those encountered by the Physician Task Force across the nation. We did find more of the abject deprivation seen by Congressmen Matsui and Pease who, along with Dr. Harper, saw clinical malnutrition and serious hunger in the District. That is, our physicians found this type situation quite easily in their travels across America.

We also saw examples of programs working. Just as we saw impoverished families sustained by AFDC and food stamps, as well as support from relatives, we found examples in many states wherein people were living on the margins, but getting by. Ironically, the families which you and I saw in the District technically were in violation of the law because they received help from relatives. Ordinarily, such support must be reported and then deducted from assistance payments. In the instances we saw, these families would have been unable to eat properly without such help from their relatives.

Finally, we found that in every state local conditions exert an influence on the degree of hunger among poor families. Many states, as you know, do not provide AFDC/UP, thus requiring intact unemployed families to go without any means of support. This increases hunger substantially. In other states, lack of sensitivity toward poor citizens, often characterized by charges of fraud and abuse, increases the burdens of already hungry Americans, many of whom choose to suffer quietly in their homes rather than suffer embarrassment and politically-motivated charges about their character.

b. We frequently found families who go without food for some days each month. In fact, that was the general experience of families we met who were reliant on food stamps for any significant portion of their food purchasing power. In addition to hearing from families themselves, emergency food providers commonly reported increased demand for food assistance each month, as the food stamp cycle comes to an end. In many cases, food providers themselves run out of food at the end of the month, thus sharpening the crisis encountered by both food stamp recipients and non-recipients who turned to them for aid.

2. Discussions throughout the country with AFDC recipients, non-recipients and welfare agency staff, revealed a number of problems with this most basic of our income support programs.

The primary concern, raised universally, is that AFDC is inadequate. In general, AFDC provides only enough for the most meager existence. In no state do recipients of AFDC, combined with the food stamp benefits, achieve an income above poverty. AFDC levels do not boost people out of poverty, but lock them in. An aspect of this is that working poor families lose benefits in direct proportion to income earned. They are, thus, unable to get ahead.

A second major concern is that AFDC/UP is unavailable in 27 of the 50 states. Families are forced to break up, and we encountered husbands forced to leave their wives and children to enable them to receive assistance which is denied so long as the father is part of the family. This is, of course, a policy which promotes family destruction. Undoubtedly this policy has some impact on the prevalence of fatherless families among the poor and perhaps on the long-term impoverishment of single-parent families.

A third issue within the jurisdiction of the Subcommittee is that potential eligibles are discouraged from applying for AFDC by a number of obstacles, including:

Complex and confusing application forms and lack of staff to help clients negotiate the application process;

Extensive requirements for documentation and verification with no room for flexibility or staff discretion;

A rushed, often adversarial atmosphere in welfare offices which makes it both unpleasant and difficult for clients to ask questions and/or get answers they need in order to apply.

While the particulars vary from locale to locale, it was our assessment that these obstacles reflect not local attitude but national policy. The states, in responding to federal regulations which impose sanctions for errors of liberality, but not for errors which unfairly deny benefits, put pressure on local welfare offices, which put pressure on individual workers who respond with pressure on clients. The operating principle that develops in these circumstances, is, "When in doubt, deny." Potential

applicants are thus discouraged from turning to the system for assistance in the first place; those who do are less likely to receive the help they need, and to which they have a legal entitlement.

The basic questions we encountered concerning unemployment compensation was that of its availability. We found, particularly in high unemployment areas of the Midwest, that working class families are hard hit by the curtailment in extended benefits. The current recession is, as you know, unique in the number of individuals it left unemployed and without benefits. A related issue is the number of unemployed whose jobs were premanently ended. The general economic recovery offers no comfort to individuals in areas where this kind of unemployment is endemic. They need extended benefits along with job-retraining.

What this Subcommittee can do—and it is clear from your recent hearing and field investigation that you already think in these terms—is to publicly explore the extent and nature of problems experienced by those relying on these programs and to propose legislation that would:

Expand AFDC benefits, bringing recipients up to the poverty line;

Build encouragement, rather than disincentives, for earning into the system;

Make AFDC/UP a federal mandate;

Require administrative agencies to streamline application procedures for AFDC;

Permit extended unemployment benefits in areas still suffering long-term effects of the 1982–83 recession, perhaps in conjunction with some realistic job search or retraining program.

3. There is no easy answer to the question of long-term impact caused by nutritional deprivation in children. The degree and nature of harm depends on the seriousness and timing of deprivation.

At the most vulnerable period of development, nutritional deprivation of the fetus in utero is associated with low birth-weight, which places the child at highest risk of infant mortality. Even surviving low birth-weight infants face increased risks of neurological and physical impairment that may have drastic impact on their ability to grow and become productive citizens.

Malnutrition during infancy is linked with cognitive and behavioral deficits later in childhood.

Malnutrition, even short-term malnutrition which may cause no overt physiological damage to a child, can deprive the school-age child of educational and social experiences that may be important to development.

Lack of adequate nutrition interacts with other aspects of poverty to impair health. For example, susceptibility to infectious disease is heightened by poor nutrition. A child who does not have access to regular preventive medical care may miss immunizations further increasing the risk of infection. Thus, the two forms of deprivation interact. Similarly, inadequate nutrition increases the absorption of toxic lead in exposed children. Poor housing conditions, in old homes with flaking leaded paint or in shelters not intended to house children, may increase that exposure. Again, the poor child is in double jeopardy.

In each of these cases, the opportunity of a child to develop normally, or to become a productive adult, and to fulfill his or her potential for a full and healthy life, is impaired.

4. When the Physician Task Force began its investigation of hunger in 1984 its members were aware of changes that had been made in public assistance programs since the start of the decade. These changes in eligibility criteria and benefit levels were enacted by Congress are widely reported in the press.

What came as more of a surprise to Task Force members, and I think the public is still largely unaware of this, is the extent to which administrative (as distinct from legislative) procedures have affected these programs and their potential beneficiaries. As we learned, administrative changes have produced a series of major de facto cutbacks in programs often making assistance unavailable to those who are legally eligible and in need. Some examples, drawn from our investigation and reported in the final report produced by the Task Force illustrate this phenomenon.

"Men who worked hard all their lives suddenly find themselves out of work when their plants close. They don't want to look to the State for help. But when they finally hit bottom . . . their worst fears come true. Paperwork and red tape are stacked so high they would have to be olympic pole vaulters to get over it"—Director, Illinois Department of Public Aid.

"It is not unusual for people in St. Louis and Kansas City to apply for aid and wait 45–60 days before a decision is rendered. Forms are long and quite difficult to fill out. Each month many families lose benefits—not because they are ineligible but for failure to report properly"—Worker, Lutheran Family Services, St. Louis.

Many Texans with a legitimate need are being kept off, or kicked off, federal food assistance programs because of bureaucratic barriers and procedural changes . . ."—Chairman, Texas Senate Committee on Hunger.

"Why, you ask do 280,000 Mississippians eligible for food stamps not receive these benefits? The answer . . . the hassle . . . many are physically unable to wait in long lines . . . loss of dignity and respect. It is demeaning to fill out forms which border on invasion of privacy. Some forms are even accusatory in nature. Yet, loss of dignity and respect prohibit some from applying"—Mississippi Welfare Commissioner.

Each of these examples illustrates a different manifestation of the problem. While these manifestations are all important—and I will discuss steps that could be taken to address them—it is important to understand first that the manifestations occur in all sections of the country.

This problem does not reflect the personal attitudes of local or state program administrators. Rather, it is a manifestation of national policy that penalizes states allegedly in an effort to reduce error-rates in the distribution of benefits. That national policy, growing out of, but we think exceeding the intent of congressional mandate, addresses only errors of liberality. States stand to lose federal dollars if they do not reduce errors of enrollment or overpayment by specific amounts. There are no penalties for parallel errors of underpayment or unfair denial of benefits.

The universal impact of this policy, intensified in regions where local or state officials are hostile to public assistance recipients, is a punitive atmosphere pervading the administration of programs. The result is the discouragement of potential recipients, and the outright denial of benefits to large numbers of eligible and needy Americans.

There are regulatory changes that could address this situation. Foremost is the development and implementation of a real quality control system that holds the states responsible for positive accomplishments, rather than just cost control, in the implementation of these programs. Cost control would be just one criterion of success in a system that also looks at percent of eligibles reached, steps to guarantee access to those who by reason of physical handicap, geographic isolation or language are effectively barred from participation at present, and swift and accurate processing of applications. Such a system would balance the federal pressure felt by states at present to withhold benefits.

In addition to the implementation at the federal level of such a balanced quality control system other positive steps would include:

Funding for outreach to potential eligibles;

More staff discretion in granting emergency assistance while applications are pending;

Control over the poliferation of regulatory changes that have been made at the federal level in the past few years. (Extensive, often confusing changes instituted without adequate staff training, lead time, or funds for new forms, computer programs and the like have resulted in a great deal of error and overwork of program staff for which potential clients pay.)

ANSWERS TO REPRESENTATIVE LELAND'S QUESTIONS

1. While we have not developed a legislative agenda as such, it is the sense of the physicians on the Task Force that food stamps is the critical program that must be expanded to improve nutritional status of needy Americans. It is the program that can be most widely available and most flexible in meeting food needs. While WIC, child nutrition and elderly feeding programs are clearly important, each reaches only a limited population and provides a limited portion of the diet. Food stamps can overlap with these programs but also serve individuals that other programs exclude.

Further, perhaps because of its general nature, food stamps has suffered, more than other food assistance programs, from the negative public image of welfare programs. It is important that Congress affirm support for the basic goal of the food stamp program by providing fiscal support for its expanded operation.

We believe the food stamp program must be expanded on the order of $2.5 to $3 billion annually, and that Congress must take steps to restrict policies of USDA which limit the number of needy and eligible citizens who are helped by the program.

2. The underparticipation of potential eligibles in the food stamp program is an extremely revealing indicator of problems with the administration of the program.

There is no mystery to the underparticipation of eligibles in the WIC program. WIC funding is capped by Congress at a level that only makes possible the participation of about one-third of the women and children estimated to be eligible.

But the food stamp program, at least in theory, is an entitlement. Its level of funding can be expanded to accommodate the level of need and of eligibility nationwide. And yet over the past few years, while poverty has increased sharply, food stamp participation has barely changed, and recently has declined. The numbers reflect an increasing discrepancy between eligibility and participation. In 1980 approximately 29 million Americans lived in poverty. In 1983 that number had increased an estimated 6 million to about 35 million people in poverty. In 1980, some two thirds of those in poverty received food stamps. Using that ratio as a rule of thumb, we would expect over three million of the newly poor to be assisted by the food stamp program. Instead food stamp participation has actually declined; some 300,000 fewer people received food stamps in September, 1984 than in September, 1980. The total discrepancy is over three million people.

The Congressional Budget Office estimates that approximately one million people were dropped from the food stamp program as a result of eligibility changes effected by the Omnibus Budget Reconciliation Act of 1981. The remaining discrepancy, more than two million people who are food stamp eligible but are not getting assistance, are the group we must explain.

In the course of its investigation, the Physician Task Force on Hunger in America encountered a variety of regulatory changes in assistance programs, particularly the food stamp program, which we attribute in our report to "mean spiritedness" on the part of the federal government. We believe these changes explain current underparticipation in the food stamp program.

The changes affect enrollment in two stages: first there are new administrative practices which discourage eligible individuals from applying for assistance or which unfairly turn away eligible applicants; second, there are practices which cut legitimate participants off the food stamp program after they are enrolled. Our visits to food stamp offices and discussions with needy individuals across the country, provide evidence of both unfair discouragement of applicants and disqualification of enrolled recipients.

Practices that we found which discourage applicants include:

Excessively complex application forms,

Constant changes in federal regulations which keep the program in a turmoil,

absence of bilingual staff where needed,

inaccessibility of program office in rural areas,

long waiting lines in offices,

inadequate staffing of programs.

The last practice listed, inadequate staffing, is particularly important. It is a cause of long waiting periods, both in offices and for receipt of benefits once an application is made. It is also a source of discouragement in its own right. When staff are overworked they become impatient with applicants. Those who in any way represent extra work are particularly disfavored. Thus, those who are most in need of help, the illiterate, the elderly, the inexperienced, are often the very people who encounter the most impatience if not overt hostility. This attitude on the part of program staff becomes a significant variable in determining the willingness of needy people to undergo the application experience. Universally, that experience was described to our physicians as humiliating, traumatic and exhausting. And staff overwork (due largely to federal regulations and restrictions) is a critical variable in creating this distressing climate.

Similar difficulties confront the enrolled food stamp recipient. Failure to comply with a reassessment requirement, failure to meet a deadline or make an appointment, inadequate verification of current financial status, all may be grounds for disenrollment. Given the general disorganization of the program, particularly with ever-changing bureaucratic requirements coming out of Washington, the recipient may find himself cut from a program for missing an appointment for which no notification has been received. Re-enrollment may take weeks or more, during which the recipient and his family must find some way to eat. When re-enrollment occurs, no restitution is made for lost benefits, even if it is clearly the program, rather than the recipient, whose error caused the cut-off. Here again, the most disadvantaged members of society are at highest risk of losing assistance because of unnecessary bureaucratic requirements.

Another group at disadvantage in the process is the working poor, who must be able to prove income from jobs that are often short-term, sporadic or hard to document.

While there is no precise estimate available on the number of people affected by such disenrollments from the food stamp program, there is no question, given national reporting of this phenomenon, that some significant number of poor people

are constantly cycling through the system, enrolled in the program, then denied assistance, and then re-enrolled after a few months of desperate need.

We have described these policies, in aggregation, as mean-spiritedness. But we do not want to imply that they reflect subjective attitudes on the part of program staff. Certainly, hostile staff are distressing to applicants, and discourage participation in the program. But staff attitude, and program policy even where staff have the best of intentions towards their clients, reflect national policy over which state and local officials may have little control. This policy on the one hand, denies program funds for outreach and for client assistance, and on the other hand requires states to reduce errors in program administration on pain of fiscal sanction. Since the only errors penalized are those which overpay the client or which enroll ineligible clients, the states are inevitably placed in an adversarial relationship with the client. When in doubt, workers deny aid to avoid fiscal sanctions. The federal government, however, does not sanction states for errors against clients.

The mean spiritedness is garbed as neutral, even efficient policy. Its impact on clients is, however, personal and dramatic. It is our sense, based on our national investigation, that it has such a powerful effect on potential and enrolled recipients as to explain non-participation in the system by some two million people.

3. While there is no definitive data on the age levels of food stamp recipients, it is our impression based on the Task Force field visits that the elderly are underrepresented in food stamp enrollment. Factors that were cited to us as explanations of this pattern include the physical difficulty the elderly poor experience in getting to program offices (particularly in rural or very cold areas), the sensitivity of elderly individuals to the stigma attached to public assistance and the minimal benefits to which many elderly are eligible because of social security income. Many food stamp administrators, for example, expressed concern about the $10 monthly food stamp allotment for many elderly citizens—an amount insufficient to serve as an adequate source of supplemental nutrition, and an amount too small to justify the subjecting of the elderly to complex bureaucratic procedures.

4. The Chicago data cited in our report involves 16 cases of marasmus, not at Cook County but at Children's Memorial Hospitial, over a four-year period. We received similar reports in the Rio Grande Valley of Texas where a nutritionist with Third World experience reported cases of marasmus and kwashiorkor, and in New Mexico from both the chief state health official, and the director of an Indian health program.

We think it likely that these reports are only the tip of the iceberg; that these cases of advanced disease in fact reflect a larger pool of malnourished people than is generally acknowledged or understood in the United States.

5. The conclusion reached by the Physician Task Force, based on analysis of data on poverty and food assistance participation, and of field investigations, is that hunger constitutes an epidemic affecting approximately twenty million Americans. While most of these individuals do not go hungry all the time, they do experience regular episodes of deprivation determined by the monthly food stamp cycle. The inadequate nutrition which results has the potential to do significant harm to the health of its victims.

Some of the effects of poor nutrition are already reflected in the health of poor Americans, particularly poor children. Among these are adverse birth outcomes, growth stunting and anemia.

Adverse birth outcomes: The United States ranks approximately 17th in the world in its infant mortality rate. Among the nations which do better in this widely-used index of child health are most countries of Western Europe and Scandinavia as well as Japan, Singapore and Hong Kong. Key to this dismal statistic is the prevalence of low birth-weight infants in the United States. Low birth-weight is involved in two-thirds of infant deaths in this country, and is in turn associated with several critical pre-natal health factors including maternal nutrition.

At present, the best means we have for assessing the birth experiences of poor women, for whom separate statistics are not determined, is to look at data on black women, not because of their race per se, but because they are disproportionately poor. We find that while 6.8% of American babies are born underweight, approximately 12.4% of black babies are of low birth-weight. The infant mortality rates parallel these statistics: the national rate of 11.5 infant deaths per thousand live births in 1982 included a baclk infant mortality rate of 19.6 dealths per thousand. In each case, the black rate is approximately twice that of whites. These figures are grounds for grave concern about the impact of hunger on all poor women and their families.

Growth stunting: Data from the CDC's Pediatric Nutrition Surveillance System reveal that of low-income children from over 30 states who comprise the system's

population, approximately 8.5% are below expected height for age. A similar figure was derived from data collected by the Massachusetts Nutrition Survey for that state's low income children in 1983.

Population-based stunting is, like infant mortality, a useful indicator of the status of the population. Stunting serves as a relatively easy-to-measure marker of deprivation. Research shows that well before growth slows down because of poor nutrition, functional changes occur which may be particularly significant in growing children. Curtailment of activity, for a small child, means loss of learning, loss of social interaction, loss of physical development. Thus, widespread stunting of growth in poor children, as is indicated by the data available, indicates significant development deprivation of these children. It is the more subtle effects at which stunting points that most concern us.

Anemia: Here again, both the CDC and the Massachusetts Nutrition Survey, as well as smaller local studies, indicate widespread prevalence among poor children. In the CDC sample, approximately 7% of poor children under age six were anemic.

The impact of anemia varies with degree. Symptoms of anemia include listlessness and fatigue, headache or dizziness. Over the long term, anemia causes slowed growth, palpitations and enlargement of the heart and impaired immune response.

For children then, these three indices reveal a major health problem related to hunger. In adults, it is more difficult to see the impact of nutrition. The markers of deprivation in children have no easily measured parallels in adults. We do know, however, that poverty is linked to increased deaths from nutrition related diseases. Cardiovascular diseases, infectious diseases and diabetes cause significant numbers of deaths among adult Americans. They are all related to nutritional status and all particularly prevalent among the poor. Thus the available data, indirect as it is, suggests a significant cost of inadequate nutrition among poor adults.

6. Failure to diagnose malnutrition and related health problems reflects a number of factors. Included among them are:

lack of attention to nutrition-related disease in medical and nursing school curricula;

the prevailing wisdom, which affects but also extends beyond medical education, that diseases related to malnutrition simply do not occur in twentieth century America;

the tendency to blame the victim, so that even when a nutrition-based condition is identified in a poor child it is identified as failure to thrive rather than malnutrition (I do not mean to suggest that the failure to thrive diagnosis is incorrect, but rather that it can be a euphemism which shifts emphasis for nutritional needs to familial inadequacies;

the fact that some impairments related to moderate malnutrition may not be identifiable on an individual-case basis. Stunting, for example, can be statistically ascribed to a population but not to a given individual unless more is known about a particular child than the simple fact of short stature;

some of the individuals at highest risk of malnutrition do not have access to regular medical care that might identify nutritional deprivation.

7. Both the members of the Physician Task Force, and the doctors with whom we met in different regions of the country, come from a variety of medical specialties. Clinical observations of hunger reflect that variety. Among the concerns noted by Task Force members based on clinical observations are the following:

Failure to thrive appearing in families concurrent with loss of benefits from government programs. A report of this pattern showing up in Boston's poor pediatric population was, in part, the inspiration for both the Physician Task Force investigation and for a major nutrition survey conducted by the state of Massachusetts. Pediatricians in Chicago report the same observation as their Boston counterparts;

Water intoxication, reported by pediatricians when parents try to stretch formula by watering it down;

Low birth-weight in babies of low-income mothers;

A condition which one physician termed "failure to thrive among the elderly," involving nutrtional deprivation and social isolation, with some symptoms paralleling those observed in childhood failure to thrive;

Exacerbation of a variety of chronic conditions among the elderly poor, notably hypertension and diabetes, by poor diet.

8. There is no nutrition surveillance system that provides current information with which to answer this question; our field investigation was not aimed at collection of data on particular nutritional deficiencies. We can, however, draw on national studies done in recent years to learn about the status of poor Americans. Such studies reveal the following:

The 1971-72 National Health and Nutrition Examination Survey found deficits in calcium, iron and vitamins A and C intake associated with income below poverty;

The Ten-State Nutrition Survey, conducted in 1968, found inadequate intake of vitamins A and C, riboflavin and some other nutrients in the low income population assessed;

Analysis of data collected for the USDA's Nationwide Food Consumption Survey in 1977-78 found that 88% of individuals purchasing food at the budgetary level of the Thrifty Food Plan, based on which the USDA sets food stamp allotments, were unable to obtain the Recommended Dietary Allowances for a set of eleven key nutrients. The most prevalent deficiencies were in calcium, magnesium and vitamin B-6, with iron, vitamin A and vitamin B-12 deficiencies also very common.

These data are suggestive but because they are outdated, provide no precise information on the nutritional status of Americans today. Discussions about the impact of policy on health are severely hampered by lack of an on-going nutrition surveillance system that would allow up-to-date assessment of populations of concern. An on-going system would make it possible to evaluate changes in American nutrition over time, thus allowing links between policy changes and nutritional status to be identified. The Physician Task Force on Hunger in America, like many other groups and individuals concerned with the impact of policy on the nutritional status of Americans, has strongly recommended that such a system be developed.

9. Questions posed above have requested information about what is known epidemiologically and what is observed clinically about the nutritional status of low-income Americans. This question allows me to go a bit further, to address not only the effects of hunger we already see occurring, but also the effects that research suggests may occur over the long-term. That is an opportunity I welcome, because after-the-fact is too late to address some consequences of hunger; we must think and act preventively.

Science does not know much about the specific implications of episodic hunger which, as you mention, is the experience of many poor Americans. We do know that acute experiences of deprivation can interfere immediately with the ability of the individual to function: to learn, if we are concerned with a child; to work if we are concerned with an adult. Socially, the implications of such losses are significant.

Over the long term, we know more about the implications of a diet that is generally inadequate. And we know that the cumulative impact of the episodes of deprivation suffered by poor Americans is nutritional inadquacy.

Deprivation in the prenatal period is linked with low birth-weight, a major factor in most infant deaths that occur in the United States. Even surviving low birth-weight infants are at high risk of long-term impairments. Cerebral palsy, blindness, deafness, learning disabilities and mental retardation are all associated with low birth-weight.

Deprivation in childhood may cause functional deficits. If hunger is protracted, growth slows down so that the body can preserve calories and nutrients for essential functions. Undernourished children are also at heightened risk of infection, and are more vulnerable to the effects of infections they sustain. The lack of specific nutrients is associated with a range of deficiency diseases, the most prevalent of which is anemia due to iron deficiency.

In small children, the impact of gross nutritional inadequacy may be a syndrome known as failure to thrive. While this syndrome is generally associated with social pathology in families, practitioners have noted recently that economic stress plays a dual role in the etiology of some cases of failure to thrive: it makes the acquisition of adequate food objectively difficult and it is a source of social stress, thus compounding problems that may already be present. Some researchers have suggested that among American children diagnosed as failure-to-thrive cases may be a number who experience kwashiorkor and marasmus, the diseases associated with drastic starvation in the Third World.

In adults as in children the consequences of malnutrition include functional impairment, greater susceptibility to infection and vulnerability to infection when it occurs, and specific deficiency diseases. The most significant effects of inadequate nutrition among adult Americans is probably the exacerbation of chronic diseases with which many middle-aged and elderly poor people are burdened. Hypertension, associated with life-threatening cardiovascular disease, and diabetes are particular causes of concern. These two conditions affect about one-fifth of the adult population in the case of hypertension and 5 to 10 percent (depending on age group and sex) in the case of diabetes. The importance of diet in prevention and treatment of these very prevalent conditions is widely acknowledged. The implication of nutritional inadequacy due to poverty is an enormous burden of illness from these two conditions alone. There is no question that policies which limit the ability of poor

Americans to purchase an adequate diet increase the prevalence and severity of these conditions.

Chairman FORD. We really appreciate your participating with us in these congressional hearings today, and we look forward to sharing with you any additional information we might be privy to in the near future. Thank you very much for coming.

The subcommittee will adjourn the hearing today.

[Whereupon, at 3:25 p.m., the hearing was adjourned.]

[Submission for the record follows:]

SUBMITTED BY MILDRED J. WEBBER, DIRECTOR OF LEGISLATIVE INFORMATION, THE HERITAGE FOUNDATION

[From the Washington Times, Apr. 17, 1985]

IS THERE A HUNGER EPIDEMIC?

(By S. Anna Kondratas, a Schultz Fellow in Health and Urban Affairs, the Heritage Foundation)

The Physicians Task Force on Hunger in America, a group of doctors based at the Harvard School of Public Health, recently released a report claiming that hunger in America is a "national health epidemic."

According to the report, "some 20 million Americans suffer from hunger." Even leaving aside questions of definition, one cannot help but be struck by the enormity of the doctors' allegation that nearly one in 10 Americans is hungry.

Ironically, many of these same physicians participated in a 1977 study which found that America's nutrition programs were a great success and that hunger and malnutrition were no longer serious problems among the poor. What happened in the few intervening years to cause such a dramatic turnaround?

To the doctors, the answer is clear: Hunger has spread rapidly because federal nutrition programs "have been weakened." Hunger has returned to the United States "primarily due to government failure," they said. In other words, it's the Reagan budget cuts again.

"Admittedly, we are not politicians," the doctors said. Yet a careful analysis of their study reveals a document that would do any political hack proud. The report has it all—emotionalism, hearsay, and anecdotes, as well as a review of past studies, some of the questionable methodology, many by obviously biased, liberal activist organizations. But does that make their report worthless?

After all, the doctors also conducted field research and found evidence of hunger. There is no reason to doubt them. There is hunger and malnutrition in the United States today. But the report certainly does not present any solid data to convince us that 20 million persons are barely surviving.

For example, contrary to media reports, the physicians did not "find" 20 million hungry (let alone malnourished) persons in the course of their survey. Indeed, the methodology for deriving that number is most peculiar and highly unscientific.

First, they took the 1983 poverty count of some 35 million, subtracted the 20 million food-stamp recipients, and got 15 million persons below the poverty line who were not receiving food stamps. They (quite correctly) state that this is a conservative estimate of the number of poor not receiving food stamps, because some of those receiving food stamps are above the poverty line. Then they decided that by definition, anyone below the poverty line "does not have sufficient income to purchase a nutritionally adequate diet," a totally unwarranted assumption based on a misunderstanding of how the poverty thresholds were determined.

Next the Task Force performed some statistical gymnastics with a few surveys even they described as not necessarily reliable to estimate how many receiving food stamps might still be experiencing hunger. Again, giving the impression that they were playing it cautious, and that their estimate was "conservative," they took the lowest survey finding (50 percent) and reduced that by half to conclude that some 5 million food-stamp recipients also suffer from hunger. There is no scientific rationale for taking half of an unreliable estimate and concluding that it is anything but a totally arbitrary number. But in politics, anything is possible.

Although the doctors are apparently unaware of such information, since 1979 the Census Bureau has been collecting household data on the number of food-stamp recipients in poverty. Since there had been no budget cuts in our "successful nutrition

programs" from 1977 to 1979—indeed, there had been substantial increases—one can safely conclude that there was no more hunger in 1979 than the doctors had cheerily documented in 1977, when they declared hunger no longer a serious problem.

What do we find? In 1979, of 26 million persons in poverty, fewer than 11 million—38 percent of poor households—were receiving food stamps. This means more than 15 million persons below the official poverty line were not receiving food stamps. If one applies the Task Force's methodology, adding to the 15 million an arbitrary 25 percent of the remaining 11 million, the result is nearly 18 million "hungry" persons in 1979—nearly one in 10 Americans, using the doctors' definition.

But the doctors found malnutrition in 1977 to be negligible. In fact, they said, what they found gave them"great professional and civic pride."

Miraculously, 15 million poor persons in the late 1970s—when inflation was raging—were able to feed themselves without government assistance. And the doctors found no serious malnutrition problems. But in the early 1980s, according to the Task Force, 15 million with no government assistance are in the throes of a major hunger "epidemic"—despite an almost negligible inflation rate.

The tragedy of reports like Hunger in America is that people conclude, from the credentials of the authors, the prestige of the Harvard School of Public Health, and the attention given it by the media, that findings are fact. They're not.

Anyone who bothered to study the report would find that the doctors stray far from scientific inquiry. The report includes a good dose of ultraliberal political philosophy and statistical and economic nonsense.

The doctors rail against inhumane bureaucracies, analyze trends in unemployment and poverty, draw analogies between today's economic conditions and the Great Depression, and make frequent references to the mean-spirited political climate created by the Reagan administration.

But they do not establish cause-and-effect relationships between present economic policies and trends and their supposed subject of study—hunger and malnutrition; they merely make assumptions.

They claim that the Department of Agriculture's thrifty food plan was designed by a computer (Horrors!) "irrespective of human need." That is inaccurate.

They also claim that nutrition budget cuts in the 1980s rate as the "sharpest and most severe in our nation's history." That's hard to dispute, since the programs have only existed for several decades and have never been cut before. But "sharp" and "severe" are hyperbole.

According to Census Bureau and Agriculture Department data in 1979, 17.7 million received food stamps, some 11 million of them under the poverty line, 6.7 million above. Of the 26 million living in poverty, 42 percent received food stamps.

In 1983, 21.6 million were receiving food stamps—some 15 million below the poverty line and 6.1 million above. Some 44 percent of those officially considered poor received foods stamps.

These figures show that (because of eligibility changes) about a half-million fewer non-poor persons received food stamps in 1983 than in 1979. But they also show that not only greater numbers, but a higher percentage of the poor were being reached by the food stamp program in 1983 than in 1979. Moreover, the average per-person monthly benefit between 1979 and 1983 more than kept up with food inflation.

In the late 1970s two out of five poor Americans received food stamps and the doctors saw no hunger crisis. In the early 1980s two out of five poor Americans receive food stamps and that supposedly indicates rampant hunger.

If the Hunger in America task force proved anything with its study, it is not that we are in the throes of a "hunger epidemic". Rather, it is that political commitment is not the mother of scientific scholarship.

[From the Washington Times, Apr. 24, 1985]

Infant Death Rate Fell Again—Did You Hear?

(By Harry Schwartz)

One of the most politically charged health statistics in the U.S. was released last month and received—as far as I could tell—no journalistic attention whatsoever.

The statistic issued was the infant mortality rate for 1984. The Department of Health and Human Services reported that last year there were 10.6 deaths per 1,000 live births, the lowest rate in U.S. history. Because it was the rate for the fourth

year of the Reagan administration, moreover, this figure provided an opportunity to make an accurate assessment of the impact that President Reagan's policies have had on the health and welfare of the U.S.'s babies. The general failure of the media to pay attention to this figure raises interesting questions about how many journalists really seek a sober, balanced account of the state of American babies' health.

What makes the new lower rate so politically charged, of course, are the frequent claims from such groups as the Children's Defense Fund that Reagan administration health and welfare policies strike viciously at the nation's babies. In the past four years we have been treated to a barrage of data about individual states whose infant mortality rate during, say, 1982 or 1983 was greater than it had been the preceding year. Small geographic areas of the U.S. have been singled out as having infant mortality rates comparable with the worst of the Third World nations. The latest gambit has been the charge that no state will reach an (unrealistic) 1990 goal for infant mortality set by Jimmy Carter's surgeon general in 1978. The whole point of this campaign has been to portray the Reagan administration as brutal and callous toward babies and to encourage Congress to pass still higher appropriations for what the lobbyists consider pro-baby purposes. And many members of the media have proved themselves patsies for this propaganda campaign year after year since Ronald Reagan took office.

The actual data yield a message in sharp contrast to the doom and gloom favored in most news stories on this subject. In 1980, the last year of the Carter administration, there were 45,526 deaths of infants under one year of age, an infant mortality rate of 12.6 infant deaths per 1,000 live births—a record low.

In 1984 there were 39,200 deaths of infants under one year old—a reduction of more than 6,000 compared with the comparable Carter administration year, and another record low. The infant mortality rate in 1984, 10.6 deaths per 1,000 live births, was 15% less than in 1980. Indeed, every year of President Reagan's first term saw a record low established in this field, as the rate dropped from 12.6 in 1980, to 11.7 in 1981, to 11.2 in 1982, to 10.9 in 1983 and finally to 10.6 last year.

This record of better infant health under President Reagan is noteworthy, too, because the U.S. is still the uncomfortable champion in the field of teen-age mothers among industrialized countries. A recent study by the Alan Guttmacher Institute found that U.S. teen-agers become pregnant twice as often as British, French and Canadian girls, nearly three times as often as Swedish girls and about seven times as often as Dutch teen-age girls. Black teen-age girls in the U.S. have the highest rate of pregnancy, but the white teen-age rate of pregnancy—83 per 1,000—is very much greater than in any of the five countries mentioned.

The babies of teen-age mothers, sad experience has shown, are most vulnerable. It is they who are most likely to die in their first year because they are born prematurely, because they have low birth weights and because their mothers have often received little or no medical attention before giving birth. Also teen-age mothers are likely to be least well informed on how to raise babies. The Reagan administration did not stop the teen-age pregnancy epidemic, unfortunately, but nevertheless from 1981 to 1984 the trend of fewer babies dying continued unbroken.

President Reagan's detractors in this field have been arguing that his attempts at economies in Medicaid and in our welfare program have imperiled babies most. The Children's Defense Fund and similar groups have proved the susceptibility of the media to such claims while ignoring the steady decline of infant mortality in the U.S. That decline shows up the rhetoric of the anti-Reagan groups for the absurd hyperbole it is.

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